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CARING INTERACTIONS: PERCEPTIONS OF PATIENTS AND NURSES

BY ©

BERNADETTE M. PAULY

A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirements for the degree of **MASTER OF NURSING**

FACULTY OF NURSING

Edmonton, Alberta

FALL, 1993

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Date: Sept, 21, 1993

ABSTRACT

The purpose of this study was to describe patients' and nurses' perceptions of a caring interaction. An additional purpose was to described the effects of a caring interaction for both the patient and the nurse. An exploratory descriptive design was chosen for the study. Data were collected through guided interactive interviews with eight nurse-patient dyads recruited from an acute care gynaecological setting. Using content analysis, three major categories of caring were developed from the perspective of patients: The nurses' way, Helping through and Going Beyond. Additionally, three major categories of nurses' caring were developed from the perspective of nurses: Establishing a link, Responding and Doing for everybody. Similarities and differences in perceptions between patients and nurses were described. Both patients and nurses described the effects of caring interactions as a very positive experience. Descriptions of caring both given and received may assist in sensitizing nurses to the perceptions and effects of caring in a gynaecological setting.

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TABLE OF CONTENTS

Chapter Page

I. Introduction 1
  A. Statement of the problem 1
  B. Purpose and rationale 3
  C. Definition of terms 4
II. Literature review 5
  A. Conceptualizations of caring outside of nursing 5
  B. Conceptualizations of caring within nursing 8
  C. Perceptions of caring 18
    Patients' experiences and perceptions 18
    Nurses' experiences and perceptions 22
    Nurse and patient perceptions 25
  D. Responses to caring 31
  E. Related studies 31
  F. Summary 34
III. Methods 36
  A. Study Design 36
  B. Setting 37
  C. Sample 38
  D. Data Collection 44
  E. Data Analysis 47
  F. Pilot Study 49
  G. Reliability and Validity 50
  H. Ethical Considerations 52
IV. Findings 54
  Part I: Similarities and differences in patient and nurses perceptions of caring 55
  A. Patient perceptions 56
    Nurses' Way 56
    Helping Through 59
    Going Beyond 66
  B. Nurses' perceptions 69
    Establishing a Link 69
    Responding 72

Doing for Everybody 79
C. Summary 81
Part II: Descriptions of shared caring interactions 83
A. Dyad #1 83
B. Dyad #2 88
C. Dyad #3 94
D. Dyad #4 103
E. Dyad #5 114
F. Dyad #6 127
G. Dyad #7 138
H. Dyad #8 146
Part III: Effects of caring interactions 161
A. Patient perceptions 161
Calmer/Less Anxious 161
Helps Healing 165
Confidence/Trust in the nurse 166
B. Nurse perceptions 171
Development of a caring relationship 171
Rewarding 173
Part IV: Additional Findings 175
A. All nurses were caring 175
V. Discussion 180
A. Limitations 180
Design 180
Sample 182
Setting 182
B. Relevance of findings 183
Patient perceptions 183
Nurse perceptions 188
Effects of caring 192
C. Implications and Recommendations 194
Nursing practice 194
Nursing Education 195
Nursing Research 196
D. Summary and Conclusions 198
References 200

Appendix A.

Patient information sheet 206

Appendix B.

Nurses information sheet 207

Appendix C.

Patient biographical data sheet 208

Appendix D.

Nurse biographical data sheet 209

Appendix E.

Consent form for patients 210

Appendix F.

Consent form for nurses 212

LIST OF TABLES

Table Page

Table 1. Characteristics of Patient Participants 42

Table 2 Characteristics of Nurse Participants 43

Table 3. Summary of themes within each dyad 154

I. INTRODUCTION

Statement of the Problem

Caring is essential to human existence. Yet, according to Chinn (1991), "for centuries knowledge concerning caring, and the methods that are required to address caring, have been largely unexamined as serious academic concerns" (p. xv). The history of nursing is rich with examples of caring and the belief that caring is integral to the practice of nursing. Only recently caring has been identified as a phenomena worthy of investigation by nurse scholars (Benner & Wrubel, 1989; Leininger, 1981, 1988; Stember & Hester, 1990; Watson, 1979, 1988; Roach, 1992). Prior to 1975, caring was not a focus of study for nurses. In the years since 1975 there has been a dramatic increase in the number of nurses studying the phenomenon of caring.

A major factor influencing the pursuit of caring within nursing has been the technological explosion and often ensuing absence of caring. Rapid advancements in science and technology have influenced the development of a highly technical illness care system focused on cure not care. In a system emphasizing cure, depersonalization of individuals and erosion of caring is rampant. Caring has the potential to refine the depersonalization of technological advances. "In the best nursing practice, science and technology are the tools for caring. Indeed, used without caring, technology becomes ominous and too frightening to be efficacious" (Benner, 1991 p. 372). As noted by Leininger (1988), this "technological takeover" has motived some nurses to think about and question the meaning of nursing and how nursing differs from other health related disciplines.

The rising costs of health care due to increased technology, increased acuity of patients and complexity of conditions has resulted in budget cuts and economic restraint within health care agencies. These developments have placed considerable stress on the ability of hospital personnel to function. Carper (1979) highlights specialization and technology as contributing to the erosion of caring. Several nursing scholars have raised concerns about the survival of caring as a value in light of the current situation in institutions, the resulting staff shortages and increasing pressures on nurses to cope with limited support and resources (Fry, 1988; Harrison, 1990; Kelly, 1988; Ray, 1988). Bergman (1990) states that nursing research is entering a new era in which caring models, as the basis for nursing practice, need to be developed through nursing research. The challenge faced by nurses is to reaffirm the value of human caring as the essence of nursing in a world where caring has been often absent or invisible. This requires the commitment of researchers to explicate the concept of caring.

A second major factor influencing the development of caring in nursing has been the National Research Caring Conferences which were initiated in the mid 1970's. The focus of these conferences has been and continues to be a forum for the exchange of ideas and the sharing of theories, research findings and clinical experiences between nurses interested in the phenomenon of caring. In 1988, the organization become international and is now known as the International Association of Human Caring. According to Leininger (1988) these conferences "awakened nurses to the need for more research studies on care, and they were significant historically because they made care a visible and worthy area of national and international study" (p. 13). The activities of the association and its members have stimulated ongoing interest by nurses in studying caring.

Caring has emerged as the essence or core of nursing (Watson, 1988; Leininger, 1988). Several authors have suggested it is not only the essence of nursing but also the moral ideal of nursing (Carper, 1979, Fry, 1989, Gadow, 1985). Furthermore, it has been suggested that caring is critical to improving patient outcomes and may be essential for growth and survival of humans (Gaylin, 1976; Leininger, 1981, 1988; Parse, 1988; Watson, 1988). However, more than theory about caring is needed if it is to become a valued element in health care. As Roberts (1990) points out, hidden caring must be uncovered through research. "While many caring actions may be hidden, and potentially undervalued, we will be more able to provide that kind of care if we know what it is, how it 'looks' in practice, and how it is transacted interpersonally. We can then value it, promote it and recognize it in our care settings" (p. 69). As a better understanding of caring is achieved, it can be recognized, rewarded and taught to students. The teaching and learning of knowledgeable and skilful caring practices must be based on a foundation of adequate research.

The small, but growing, body of caring research in nursing has focused on the meanings and behaviors associated with caring from the unique perspectives of the patient and the nurse. Theoretically, caring, practised interpersonally, produces shared meanings for the one caring and the one cared for. Stember & Hester (1990) state that, for a science of caring to be extended, it is imperative to conduct research as to the attributes of a caring relationship. "Even though we sometimes judge caring from the outside, as third-persons, it is easy to see that the essential elements of caring are located in the relation between the one-caring and the cared for" (Noddings, 1984, p. 8). The congruence or incongruence of nurse and patient perceptions of caring has not been explored within shared interactions. Additionally, little is known about patients and nurses perceptions of caring within the context of their relationship.

Purpose and Rationale

The purpose of this research is to describe nurse and patient perceptions of caring in the context of a shared interaction in an acute care hospital setting. An additional purpose is to gain an understanding of the effects of caring interactions for both patients and nurses. The findings of this study may facilitate nurses to comprehend caring and its' role in the provision of nursing care.

Research Questions

There are three research questions for this study. First, what are the perceptions of both the patient and the nurse of a shared caring interaction? Secondly, what are the similarities and/or differences in patient and nurse perceptions of a shared caring interaction? Lastly, how does the perception of caring affect the patient and the nurse?

Definition of Terms

The purpose of this study is to understand patients' and nurses' perceptions of the meaning and experience of caring. Therefore, caring has not been defined and is defined by the participants in the study.

II. LITERATURE REVIEW

The term caring has been plagued by an aurora of ambiguity and complexity that has lent confusion to this phenomenon within nursing (Leininger, 1988; Morse et al., 1990). In fact, by its very nature, caring is an often elusive and hidden component of nursing practice. From a review of the literature, Morse et al. found that there was a lack of agreement as to the common use of the term. For the purpose of this literature review, conceptualizations of caring will be discussed to provide a theoretical understanding of this phenomenon as documented in the literature. The literature review has been organized into four major categories: conceptualizations of caring from disciplines outside of nursing, conceptualizations of caring within nursing, perceptions of caring according to patients and nurses and responses to caring. A fifth category will discuss several studies related to investigation of the phenomenon of caring.

Conceptualizations of Caring outside of Nursing

Writers, from the disciplines of philosophy and psychology, have influenced the development of the concept of caring within nursing and for that reason need to be considered in a review of the literature on caring. Philosophers such as Buber (1970), Heidegger (1977), Marcel (1969), and Mayeroff (1971) have discussed the fundamental nature of caring to existence. Heidegger views caring as a universal phenomena that is fundamental to being in the world. "To be is to care". In his Letter of Humanism, he states, "For this is humanism, meditating and caring, that man be human and not inhumane, 'inhuman', that is, outside his essence" (p. 200). According to Marcel, a feeling of caring is communicated through the presence of another. "It is an undeniable fact, though it is hard to describe in intelligible terms, that there are some people who reveal themselves as 'present' -that is to say, at our disposal- when we are in pain or need to confide in someone, while there are other people who do not give us this feeling, however great is their good will" (p. 25). The most attentive listener is only present and available to care if he can make room for another in himself. "The truth is that there is a way of listening which is a way of giving, and another way of listening which is a way of refusing, of refusing oneself; the material gift, the visible action, do not necessarily witness to presence" (p. 26). Marcel believed that presence is revealed in an instant and is not bound by time.

Buber (1970) discusses two possibilities for relations in the world: I-Thou relationships and I-It relationships. The I-Thou relationship is characterized by seeing the other as a presence. In an I-Thou relationship, I respond with my whole being to You and the potential for healing is created. In an I-It relationship, I recognize It as an object. The I-It relationship is one of detachment and non-involvement. An inherent danger in a system fraught with technology and emphasizing cure is the focus on the objective body of the patient. We speak at or about rather than with patients. When the focus is on the objective body, I-It rather than I-Thou relationships emerge. In an I-It relationship, the detached and objective stance of individuals can depersonalize both the individual who is ill and suffering and the caregiver. Buber also supports Marcel's view of intersubjective relationships in an I-Thou encounter. According to Freidman (1976), Buber referred to the 'sphere of between' as the common ground in relationships. The 'dialogue' is that which occurs in the common ground and the meaning of the 'dialogue' is found in the exchange rather than in one or the other involved in the relationship. The 'dialogue' may be written or spoken, the intent is to experience the event from both perspectives. His view provides a framework for caring relationships.

Mayeroff defines caring as "helping another grow and actualize himself, a process, a way of relating to someone that involves development" (p. 1). Caring, as a process, is primary and involves a relationship between one with the ability to care and the other with the ability to be cared for. He identifies eight major ingredients in caring: knowing the self, alternating rhythms, patience, honesty, trust, humility, hope, and courage. In his view, caring gives order and meaning to life. Mayeroff developed these ingredients of caring through philosophical reflection. Many nurse scholars have utilized Mayeroff's work in developing their conceptualizations of caring (Carper, 1979; Leininger, 1981; Gaut, 1983; Roach, 1987; Watson, 1988).

Within psychology, May (1969) and Gaylin (1976) have discussed the essential nature of caring. According to May (1969), care is the source of both love and human tenderness. Care is a state characterized by concern and involvement and is a type of intentionality. "Though it goes beyond feeling, it begins there. It is a feeling denoting a relationship of concern, when the other's existence matters to you" (p. 303). Gaylin (1976) states that caring is critical to the development and survival of humans. "If there is one fact founded in his biology, essential to his survival and uniquely his own, it is that Homo Sapiens is supremely a loving animal and a caring one" (p.17). Each of these writers affirms the fundamental nature of caring to human existence.

Feminist thinking outside of the nursing profession has influenced several nursing authors. In particular, the contributions of Gilligan (1982, 1988) and Noddings (1984) have had considerable impact on conceptualizations of caring within nursing. Gilligan (1982), a developmental psychologist, found that the moral development of the girls and women she studied seemed to differ from Kohlberg's more traditional held views of moral development. According to Kohlberg, moral development occurs in stages and that the highest level of moral thinking is rooted in a perspective of justice characterized by logical rational decision making. Gilligan hypothesized that there are two modes of moral judgement, that of justice and that of care. Following additional research with both men and women, she concluded that "(1) concerns about justice and care are both represented in people's thinking about real-life moral dilemmas" and that people tend to focus more heavily on one orientation than another; and "(2) there is an association between moral orientation and gender such that both men and women use both orientations," although a care focus is more likely to be presented by women (Gilligan, 1988, p. 82). From Gilligan's point of view, caring is relational, based on receptivity and response to another, and informs ethical decision making.

From an educational perspective, Noddings (1984) argues that caring is an ethical way of being in relationships. In her view, caring relationships are characterized by "engrossment and motivational displacement on the part of the one-caring and a form of responsiveness or reciprocity on the part of the cared-for" (p. 150). The one caring feels with the other and acts to promote the others' well-being and the one cared for is receptive and responsive to the one caring. She states that "As we examine what it means to care and be cared for, we shall see that both parties contribute to the relation; my caring must somehow be completed in the other if the relation is to be described as caring" (p. 4). She believes that ethical caring in practice is rooted in natural caring. Natural caring is defined as "that relationship in which we respond as one caring out of love or natural inclination" (p. 5). In ethical caring, we act out of natural caring, the remembrance of natural caring, or the desire to be virtuous. She contends that an ethic of care is the basis for the development of a feminist approach to ethics.

Conceptualizations of Caring within the Nursing

Within nursing, several theorists believe caring to be the essence of nursing (Benner 1984, 1989; Leininger 1981, 1988; Parse, 1988; Roach 1987; Watson 1979, 1988) . Leininger (1988) has been a pioneer in the advancement of caring within the nursing profession. She contends that caring is the essence and unifying domain of nursing. She defines caring as those "actions directed toward assisting, supporting, or enabling another individual (or group) with evident or anticipated needs to ameliorate or improve a human condition or life way" (p. 156). Caring is essential for human survival, growth and development. In her research, she has studied caring in several cultures utilizing ethnographic methods. From her work, she developed a taxonomy of 28 caring constructs. She encourages the development of caring from an transcultural perspective that illuminates the emic point of view. The emic perspective provides insight into cultural similarities and differences that can be used to guide the caring practice of nurses working with other cultural groups. Leininger has consistently advocated the use of qualitative research methods to study caring from the perspectives of both the recipients and givers of care to further develop caring as the essence of nursing.

Jean Watson has become one the leaders of the caring movement within nursing. She describes nursing as being the human science of caring because it encompasses both scientific and humanistic dimensions (Watson, 1979, 1988). In Watson's view, caring is the 'core' of nursing. In her view, caring as a way of being in the 'moral ideal of nursing' that protects, enhances and preserves "humanity by helping a person find meaning in illness, suffering, pain and existence" (Watson, 1988, p. 54). She has delineated ten carative factors which form the foundation of transpersonal caring relationships that influence health and illness outcomes. The 'carative factors' were developed "from a humanistic philosophy that is central to caring for another human being and that is founded on a steady growing scientific basis" (Watson, 1979, p. 7). The ten 'carative' factors are:

(1) The formation of a humanistic-altruistic system of values,
(2) Instillation of faith-hope,
(3) Cultivation of sensitivity to self and others,
(4) Development of a helping trust relationship,
(5) Promotion and acceptance of the expression positive and negative feelings,
(6) Systematic use of scientific problem solving method for decision making,
(7) Promotion of interpersonal teaching and learning,
(8) Provision of a supportive, protective, and(or) corrective mental, physical, sociocultural, and spiritual environment,
(9) Assistance with the gratification of human needs,
(10) Allowance for existential phenomenological forces (p. 9-10).

According to Watson (1988), caring occasions or moments occur when the nurse meets the client in person to person contact; that contact being person to person in an I-Thou relationship. In the caring moment, both nurse and patient decide how to be and what to do with the moment. There is an intersubjective exchange of thought and feeling in which meaning is created. The moment provides opportunities to identify with the other and to learn from the other. Both the client and the nurse are affected by the experience and it becomes part of their history. From Watson's point of view, the human to human exchange in transpersonal caring relationships has the potential to influence healing.

Roach (1992), building on philosophical and theological perspectives defines caring as "the human mode of being" (p. 2). Strongly influenced by Heidegger, she believes that to care is part of being human and we care because we are human beings. According to Roach, caring has a number of entailments. Firstly, caring entails the capacity to care which is part of being human. "Caring involves the calling forth of this capacity in ourselves and in others through affirmation of that capacity and through its development" (p.47). Secondly, caring entails a responsivity to the other as someone who matters, someone who is of value for him or herself. Thirdly, caring is the actualization of the capacity to care and is expressed in specific moments through concrete behaviors. Roach (1991) believes that caring is not unique *to* nursing or any profession in that it does not distinguish nursing from other professions. "Rather, caring, is unique *in* nursing as the concept which subsumes all the attributes descriptive of nursing as a human, helping discipline" (p. 9). The task of the professional disciplines is the professionalization of caring through the affirmation of caring as the human mode of being and development of the capacity to care.

Roach (1992) described the attributes of professional caring as compassion, competence, confidence, conscience and commitment. These attributes are expressed in specific concrete acts of caring. The 5C's mentioned above answer the ontical question, "What is the nurse doing when he or she is caring?" Roach defines compassion as participation in the experience of another that involves sensitivity, being present and fully human. Competence is defined as the "State of having knowledge, judgement, skills, energy, experience and motivation required to respond adequately to the demands of ones' professional responsibility" (p. 61). Compassion and competence are interdependent and one is dependent of the other. Confidence is the quality that fosters the development of trusting relationships which are characterized by trust, honesty and respect. Conscience is defined as the state of moral awareness, "a compass directing one's behavior according to the moral fitness of things" (p. 63). The caring person is alert and sensitive to the moral nature of things. Conscience is developed through the experience of valuing self and others. Lastly, commitment is the deliberate choice to act in accordance with ones' desires and obligations and is essential to caring. Caring breaks down without commitment. Roach states that the 5C's are neither exclusive nor exhaustive. Rather the 5C's suggest a broad framework that encompasses categories of human behaviors for the expression of professional caring.

Benner (1984) using phenomenological methods studied the experiences of expert caring nurses. She found that caring was primary to the practices of these nurses and was deeply embedded in their practice. Benner (1989) states that caring is primary and sets up what matters to an individual, is an enabling condition of connection and concern, and sets up the possibility of giving help and receiving help. Acts done in a caring and non-caring way may result in quite different consequences. "We must consider the caring context because the nature of the caring relationship is central to most nursing interventions" (p. 4-5). Expert caring practises depend on the nurses' involvement with the patient and incorporate both practical and theoretical knowledge.

Parse (1988) considers caring from a human science perspective. She defines caring as "risking being with someone towards a moment of joy" (p. 130). The nurse engages in an open, authentic relationship with the client in which growth is possible. The nurse is truly present and attending to client which is essential to being with the client. The moment of joy is the sharing of suffering and joy that potentiates healing. "In this way healing emerges from caring" (p. 131). Both patient and nurse are affected by the experience and engaged in the process of being and becoming through their connectedness in the moment.

Recently, Eriksson (1992a, 1992b, 1992c) has proposed a theory of caring developed using philosophical methods and based on qualitative research done with patients and nurses on the meaning of caring communion. She contends that suffering is the basic category of caring and gives caring meaning. "Suffering gives caring its character and identity and all forms of caring aim in one way or another to alleviate it" (1992a, p. 123). Caring occurs in the context of a caring communion or an unselfish relationship between the patient and nurse. Caring communion is defined as "the ability to do good for another person" and is characterized by "fighting together, succeeding, being together and going through something together" (1992b, p. 208-209). In her study, patients described caring communion as "the experience of being the subject of something special, the experience of being someone's responsibility, and the experience of being with someone willing to do good" (1992c, p. 93). Nurses described caring communion as being present to the patient, having served and cared for someone in a special way. According to Eriksson, true caring occurs when the nurse acting in the spirit of caritas (caring based on human love) alleviates the suffering of the patient and creates the possibility for growth.

Within nursing, caring has been explored from a philosophical perspective by several other authors (Bevis, 1988; Dunlop, 1986; Gaut, 1983; Griffin, 1983, Ray, 1988). According to Gaut (1983), there are two dimensions of caring: 'caring for' and 'caring about'. The 'caring for' refers to the doing for another, while the 'caring about' is the affective component and entails a valuing of the other. "Whether certain actions will count as caring is dependent of what the action is, the intention of the doer, and the context in which it is done" (p. 317). To describe the activity of caring, Gaut suggests that there are three necessary and sufficient conditions. The nurse must have an understanding of the patient's needs and know what could be done to improve the patient's situation. Secondly, the nurse must plan and implement activities as a means for effecting positive changes in the patient. Thirdly, the effectiveness of the nurse's actions must be evaluated from the perspective of the client. Gaut's theoretically adequate description of caring outlines a process of caring which is action orientated and context dependent.

Griffin (1983) states that caring has both an activities and attitudes component. The activities component is similar to Gaut's 'caring for', whereas the attitudes component is like 'caring about.' Griffin defines caring as "a more or less long term disposition to act/feel in certain ways which involves emotional states" (p. 291). Dunlop (1986) states that nursing is a form of caring. She delineates two forms of caring: caring in its old sense and caring in an emergent sense. Caring in its older sense refers to care of the physical body and in an emerging sense to a form of love. According to Dunlop, it is caring, skilfully practised, in both senses that is recognized as expert nursing practice.

Bevis (1988) and Ray (1988) agree that caring is related to love and facilitates mutual growth and self-actualization. Bevis defines caring as a "Feeling of dedication to another to extent that it motivates and energizes action to influence life constructively and positively by intimacy and mutual self-actualization" (p. 50). Caring is both a process and an art. Caring is most closely related to aspects of *filia and agape* forms of love. Based on her work, she believes caring has four stages: attachment, assiduity, intimacy and confirmation. In her view, there are several factors which affect the process of caring. The most influential of these is culture because expressions and actions of caring are culturally conditioned. The other factors are values, personal and financial costs, exclusiveness, maturational level, scripts, stress levels and time. As an art, she believes caring is a life force that requires commitment to caring, lifelong study of theory and philosophy, and continual practice.

Ray (1988), in her philosophical analysis of caring, found the recurrent theme of growth or mutual self-realization in references to caring. She believes that growth or nurturing of another is the central focus of nursing. From her point of view, caring suggests a form of love that is other directed and manifested in being truly present to the other. She proposes the following concepts as representing love and presence in nursing:

authenticity, availability, attendance and communication which includes interest, acceptance, touch and empathy. Growth is facilitated through dialogue between patient and nurse. Ray believes that recent technical-scientific advances, competition for physician services have led to a focus on curing in healthcare. These events combined with the relatively powerless position of nurses has made it difficult to sustain the caring ideology of nursing. She argues that research, education and institutional change are desperately needed to reestablish caring as the central focus of nursing.

From the her work, Swanson (1991) has developed a middle range descriptive theory of caring. She has studied caring in three perinatal contexts: experiences of caring by women who suffered a miscarriage (Swanson Kauffman, 1986, 1988), caring provided by parents and professionals in a newborn intensive care unit (Swanson, 1990), and according to socially at-risk mothers who received long-term, intensive public health nursing interventions (Swanson, 1991). In her first study of the caring needs of women who have miscarried, she identified five categories of caring: knowing, doing for, enabling, being with and maintaining belief. In a second phenomenological study, Swanson (1990) explored the experience of what it is like to be a provider of care in NICU. Her sample of nineteen participants included parents, physicians, nurses, a social worker and an ethicist. Four processes of providing care were derived from the analysis: caring as acting to preserve human dignity and restore humanity which included the five categories identified in the previous study as subcategories, attaching by becoming closer and more familiar with the infant, managing responsibilities, and avoiding bad outcomes to diminish negative consequences. She concluded that caring occurs with the processes of attaching, managing responsibilities and avoiding bad outcomes. In her third study with socially at risk mothers, Swanson (1991) asked recipients of a long term intensive nursing intervention to describe the nurse-patient relationship post-intervention. In this study, the five caring processes of knowing, doing for, enabling, being with and maintaining belief were confirmed and refined.

Swanson (1991) defines caring as "a nurturing way of relating to a valued other toward whom one feels a personal sense of commitment and responsibility" (p. 165). She believes that caring consists of the five processes: knowing, being with, doing for, enabling, and maintaining belief. Each of the five processes has identified subdimensions. Knowing is the understanding of the personal meaning of event for the other and includes avoiding assumptions, centering on the one care for, assessing thoroughly, seeking cues and engaging the self of both. Being with is being emotionally present to the other and involves being there, conveying ongoing availability, sharing feelings and not burdening the one cared for. Doing for "entails doing for the other what he or she would do for the self if it were at all possible" and includes comforting, anticipating, performing competently, protecting and preserving dignity (p. 164). Enabling means facilitating the others' passage though life transitions or unfamiliar events and includes informing, supporting, focusing, generating alternatives and giving feedback. Lastly, maintaining belief is having faith in the others ability to get through the event and have a meaningful future. Each of these caring processes were cross-validated with Benner's helping role of the nurse (1984) and Watson's carative factors (1979).

Several authors have attempted to integrate differing conceptualizations of caring. Boykin and Schoenhofer (1990) examined theories of caring using 5 categories of questions proposed by Roach (1992) as the their framework for analysis. They contend that caring is unique to nursing and has the "power to unify nursing practice, education, administration, and research" (p. 155).Their framework consisted of ontological, anthropological, ontical, epistemological, and pedagogical questions about caring in nursing. The first three categories inform the development of extant theory of caring in nursing. Examination of the ontological dimension or "being" of caring yielded an understanding of caring which values human wholeness, potential of persons for being and becoming, and engagement with others. The anthropological dimension answers questions about "what it means to be a caring person." The capacity to care is part of being human and is enhanced by self reflection and finding meaning in one's own life. Exercising the capacity to care "is an actualizing experience" for both the nurse and the client (p. 150-151). The ontical dimension is concerned with question about the function and ethic of caring in nursing such as "What is a nurse doing when she or he is caring?" and "What obligations are entailed in caring?" Each of the theorists provide insight into the answers to these questions in the development of their theories and will be discussed later. The epistemological and pedagogical category "guide the organization of substantive knowledge for purposes of teaching and learning" (p. 149). Nursing curricula need to be organized and incorporate strategies that reflect the richness and potential of caring in nursing.

Pollack-Latham (1991) conducted an indepth analysis of caring and it's critical attributes. She analyzed caring in three different interpersonal dimensions, that of personal, social and professional relationships. She concluded that the caring act is has a fundamentally interpersonal nature, "...entails minimal reciprocity and usually involves an unequal caregiver and recipient relationship" and is facilitated by the participants' awareness of their role in the interaction (p. 189). Each of these factors affects the caring process. Using a concept analysis approach, she identified five critical attributes of the caring process: (1) accurate perception (knowing) of the situation, the recipient of care and their needs which involves knowing self and knowing based on experience (2) knowing the other through the use of facilitating methods such as true presence, respecting the other, positive feeling toward the other and creating an open atmosphere, (3) methods which demonstrate caring include observable instrumental and expressive behaviors, (4) validation and evaluation that caring has been completed in the other has consequences for both patient and nurse, (5) the potential outcomes of caring for both recipient and giver of care include health for the recipient and potential growth for both. She suggests that the process of care could be further studied and defined through nurse-patient dyad descriptions of the caring process and its outcomes.

Several authors have considered caring to be a moral way of being that preserves the humanness and dignity of persons (Benner, 1991; Bishop & Scudder, 1991; Carper, 1979; Fry, 1989; Gadow, 1985, 1990, Watson, 1988). Gadow (1985) views caring as a moral ideal committed to a particular end; that end being the protection and enhancement of human dignity. Technology has the potential to increase the individual's sense of other as object and poses a threat to dignity. There is an impersonal regard for the body as an object rather than a regard for the lived body or the patients' experience of their body. "Both elements of otherness, the apparatus and the expert, threaten to disrupt personal integrity, and thus to violate dignity, by removing patients from the centre of their experience" (p. 36). For the nurse, the dilemma is to fulfil a moral commitment to dignity while monitoring the objectiveness of patients. Gadow suggests two approaches for affirming the patient's integrity: truth telling and touch. Her ideal of caring involves both the patient and the nurse intersubjectively. The involvement of the patient and the nurse differs in terms of their focus, intensity, and perspective (Gadow, 1990). In the caring ideal, "... that mutuality becomes the moral foundation of nursing: commitment to the dignity that distinguishes persons from objects" (p. 43). Fry (1989) states that caring is the moral ideal of nursing. She has proposed three models of the caring relationship that might serve as the basis for a theory of nursing ethics.

From a review of the literature on caring, there is agreement that caring is the central and unifying component of nursing. Numerous theoretical conceptualizations of caring have emerged and there is a rich dialogue about the nature, process, action and outcomes of caring. However, no accepted definition of caring has been developed and many of the theoretical hypotheses require validation and confirmation through additional research. In fact, a single definition, theory or model may be unable to capture the unique and differentiated nature of caring in different settings and contexts. Due to the complex nature of caring, study in a variety of contexts and settings is required. Additionally, many nurse scholars and writers have advocated that more research and attention to the development of caring within nursing is needed if caring is to remain the central focus of nursing (e.g. Benner & Wrubel, 1989; Leininger, 1988; Roach, 1991; Watson, 1988).

Perceptions of Caring

Nursing research on caring has primarily focused on the perceptions of caring. Nurse researchers have utilized a variety of qualitative and quantitative approaches to identify and describe caring behaviors and caring experiences. Warren (1988) in her review of the nursing literature identified several studies designed to determine what caring is and means to people. She reported that the first study on caring was conducted by Henry in 1975 who interviewed homecare patients to determine what nurses do that indicates caring. Over the past twenty years, caring research has continued to grow. Several researchers have described patients' perceptions and experiences of caring using both qualitative and quantitative methods. Others have described perceptions and experiences of caring from the perspective of nurses. Some researchers have identified and described the perceptions of both the patient and the nurse for the purpose of comparing and contrasting their perceptions.

Patients' Experiences and Perceptions of Caring

Both qualitative and quantitative research studies have been utilized to describe patients' experiences of caring and perceptions of nurse caring behaviors. Qualitative studies have been conducted by Brown (1986), Lemmer (1991), Paternoster (1988), Reiman (1986), Sherwood, (1991), Swanson-Kauffman (1986, 1988). Phenomenological methods were used by all these researchers except for Lemmer. Brown interviewed 50 hospitalized medical or surgical patients to obtain their perceptions of experiences in which they felt cared for by a nurse. From her analysis of their descriptions of critical incidents of nurses caring, eight themes emerged: Recognition of individual qualities and needs, reassuring presence, provision of information, demonstration of professional knowledge and skill, assistance with pain, amount of time spent, promotion of autonomy, and surveillance (p. 58). Brown also reported that when a patient experienced an immediate threat to well-being, the patient felt cared for when a knowledgeable, competent nurse recognized the situation, intervened quickly and continued to moniter the patient. When there was no physical threat, a patient felt cared for when the nurse-patient interactions focused on recognizing the patient's individual qualities and needs and facilitated patients' autonomy. Spending more time with the patient than they perceived as necessary, emerged as an underlying theme in may of the incidents by these patients and was important in patients feeling cared about.

The purpose of Swanson-Kauffman's (1986, 1988) study was to describe the human experience of miscarriage and the caring needs of the women who miscarried. She interviewed 20 woman who miscarried before 16 weeks gestation. From the analysis of two open ended interviews with each participant, she described five categories of caring: knowing, being with, enabling, doing for , maintaining belief. Knowing is the understanding and appreciation of the personal meaning of the loss for each woman. Being with goes beyond knowing to the need for others to actually feel with the woman some of her loss. To feel, not as deeply as the woman, but with her. Enabling facilitates the woman to grieve and get through her loss by encouraging the express of feelings, keeping her informed, explaining and being honest. Doing for is having others do things for her during her time of grief and includes comforting activities. Lastly, maintaining belief meets the woman's need to have others believe in her ability to get through the loss and eventually have another child.

Paternoster (1988) studied the affective dimensions of nurse caring behaviors. She interviewed twelve random selected hospitalized patients and asked them to describe an experience in which they felt 'cared about ' by a nurse. Patients perceived nurses as caring when they were solicitous, dependable, aware of and giving attention to the patient's comfort needs, possessing a positive affect and communicated a willing acceptance of the responsibilities of the caring relationship. She felt that the informants in her study were speaking of a specific nurse when they were describing incidents and could have named the nurse had they been asked.

Reiman (1986) asked ten patients to give their description of nurse-client interactions that they perceived as caring and non-caring. She developed exhaustive descriptions of the essential structure of caring and non-caring nurse-patient interactions from the patient's perspective. The most important aspects of caring from the patient's perspective were the nurses' existential presence and recognizing the patient's uniqueness through listening and genuine interest in the patient. In contrast, non-caring interactions were characterized by nurses being there to get the job done and with brief physical presence. The patients felt their uniqueness was not recognized as the nurse did not listen or appeared too busy. Lack of technical competency was not cited in her descriptions of non-caring. Reiman concluded that non-caring interactions are in the realm of I-It relationships. Both Paternoster (1986) and Reiman (1986) found that the nurse being present and available were key variables in the patient's experience of caring.

Sherwood (1991) using phenomenological methodology identified and described patients' perceptions of demonstrations of nurses' caring. From analysis of interviews with ten post-operative surgical patients, she described five themes as essential to the demonstration of nurses' caring. They are assessing needs, planning care, intervening, validating, and interacting. Each of the five themes were considered to be fluid, dynamic and always present. It should be noted that four of the five themes are directly reflect the steps in the nursing process. It seems that the themes were imposed rather than emerging from the descriptions of the participants.

Lemmer (1991) explored bereaved parents' perceptions of caring by nurses and physicians during perinatal bereavement. She interviewed fifteen couples three to eight months postbereavement. Using aspects of grounded theory methodology she described two major categories of caring: taking care of and caring for or about. Each category was distinct from the other in relation to the types of needs that were met. The 'taking care of' category included those activities that were designed to meet the physiological and safety needs of the mother and babe by providing expert care or to meet the informational needs of the family. The 'caring for or about' category were "those activities undertaken that demonstrated to parents a sensitivity to and am empathic awareness of the emotional pain of bereavement and a desire to help them through it" (p. 480). There are five subcategories of 'caring for and about': providing direct emotional support, providing individualized, family centered care, acting as a surrogate parent, facilitating the creation of memories, respecting the rights of parents. She concluded that further research is needed to determine which interventions best facilitate the parents' ability to nurture their dying infant.

Cronin & Harrison (1988) asked twenty-two patients, who had suffered a myocardial infarction and were in a coronary care unit, to identify nurse caring behaviors perceived as indicators of caring. They collected data using open-ended interviews and the Caring Behavior Assessment (CBA) instrument. The CBA, based on Watson's (1979) ten carative factors, was developed by the researchers and consists of 61 nursing behaviors ordered in seven subscales. Patients were asked to rank order on a five point Likert -type scale the extent to which each of the 61 nurse caring behaviors communicated caring to them. Face and content validity was established by a panel of content experts.

In their study, Cronin and Harrison (1988) found that patients rated the following two nurse caring behaviors as most important: 'make me feel someone is here if I need them' and 'know what they are doing.' The least important behavior was 'visit me when I move to another hospital unit.' The subscale 'assistance with gratification of human needs' was ranked the highest by these patients and included items such as 'knows how to handle equipment and 'check my condition very closely.' Patients identified instrumental behaviors that focused on physical care rather than affective behaviors as most important. Their findings are similar to other studies conducted using quantitative methods to determine important nurse caring behaviors (e.g. Larson, 1984, 1987; Mayer, 1986).

Nurses' Experiences and Perceptions of Caring

Several researchers have studied perceptions of caring from the perspective of nurses (Ford, 1990; Forrest, 1989; Kahn & Steeves, 1988; Morrison, 1989, 1991; Ray, 1987; Wolf, 1986). Ford (1990) interviewed six nurses to obtain descriptions of their experiences of caring with cardiac patients. Using phenomenological methods, she analyzed these nurses' experiential accounts of caring. Six themes emerged from her analysis: Sensing the patient's vulnerability, beyond the call of duty, being in tune with the patient's world, being attentively present, centering on the patient, and being comfortable with the patient. In sensing the patient's vulnerability, the nurse senses and picks up on cues and connects with the patient. The nurse goes beyond the call of duty when she becomes personally involved and the patient's concerns become her concerns. Being in tune means having a feeling and knowing what is happening. When the nurse is attentively present, she takes time to listen and is totally focused on the patient as subject. Centering means paying attention to the patient in the encounter. Lastly, caring makes it comfortable for the nurse to be in an uncomfortable situation. Ford concluded, "That caring for is a way of doing and caring is a way of being" (p. 162). Additionally, caring is rooted in sensing the patient's vulnerability and and involves a mindfulness that requires the nurse to invest something of herself in the process. In return, she is enriched. She thought that caring is draining and that nurses need time to recharge between encounters.

Using a phenomenological method, Forrest (1989) studied the lived experience of caring for practising nurses. She asked the research question "What is the essential structure of caring?" Seventeen nurses participated in her study from a variety of clinical areas with various levels of experience and education. These nurses described caring as being involved with patients, that is having a deep feeling for the patients' experiences, and interacting in a sensitive way that anticipates and responds to patients' needs. Nurses in this study were also asked to identify what affects caring. They indicated that caring has the potential to increase vulnerability, create dilemmas, is affected by who the nurse is, the presence of bureaucratic hierarchies, and the availability of support systems.

Kahn & Steeves (1988) asked twenty-five graduate nurses to describe experiences from clinical practice that illustrated caring and caring relationships. Using a hermeneutical design, they identified four overall themes which were thought to reveal the overall structure of caring. The identified themes were ideological context of caring, liking as the basis for caring, praxis, and factors affecting the establishment of caring relationships (attributions for caring). Central to the theme of 'ideological context' was the notion that caring is essential to the identity of the nurse and is part of everything she does. 'Liking as the basis for caring' included the varying degrees of affection that exist between the patient and the nurse. Praxis, or the actions of the nurses in face to face encounters with patients, included both physical and nonphysical interventions associated with caring. Physical interventions included making the patient more comfortable and nonphysical interventions were activities such as counselling or crisis intervention. The 'attributions for caring' focused on the nurses ability or inability to establish caring relationships. Nurses described themselves being drawn to patients who were seriously ill, had multiple problems or were alert, outgoing and personable. These nurses found it difficult to establish rapport with patients if they were too physically tired or had too many patients to care for. Additionally, they found if difficult to establish rapport because of certain characteristics of their patients such as being demanding, dirty, cool, withdrawn and having low self-esteem. Caring raised value conflicts with ethical implications for these nurses.

In a British study, Morrison (1989, 1991) explored professional nurses' perceptions about the meaning of caring in practice. A sample of 25 experienced charge nurses from various clinical specialties were asked about their perceptions of caring and to examine perceptions of themselves as caregivers. Using a repertory grid interview technique based on Kelly's Personal Construct theory, participants were given a list of eight role titles: A caring nurse, an uncaring nurse, the most caring person I know, the least caring person I know, a person I care a lot for, a person I don't care much for, myself as a carer, and how I would like to be as a carer (ideal self). Participants were asked to match and identify real persons to the first six role titles. Then participants were asked to develop words or phrases to describe similarities and differences between the identified individuals and themselves as as caregiver. Morrison (1991) reported the results of the qualitative content analysis of the constructs obtained from the nurses in this study. A seven category scheme for the 200 constructs collected was developed and the constructs were classified according to personal qualities, clinical work style, interpersonal approach, level of motivation, concern for others, use of time and attitude. The constructs in each category were classed as caring or uncaring. Of the 200 constructs, 39% were classified as personal qualities such as being kind, patient and genuine. An additional 37% divided between clinical work style and interpersonal approach. Clinical work style included treats everyone as an individual and meets individual needs. An interpersonal approach incorporated constructs such as approachable, sensitive, listens and is empathic. Morrison concluded that majority of constructs were related to psychological care rather than physical care.

In Morrison's (1989) examination of nurses' perceptions of themselves as caregiver, discrepancies between self and ideal self in terms of caring role emerged. Using a seven point Likert type scale nurses were asked to rate themselves on the eight bipolar constructs developed during the first part of the study discussed earlier. These nurses perceived themselves as lacking in certain skills within their caring role. According to Morrison, these discrepancies may have been due to unrealistic expectations, lack of appropriate training and knowledge necessary to fulfil caring roles, differences in values of the system and values of the individual nurse (ie. technical competency being more highly valued by the organization than interpersonal competency). In this study, the personal costs of caring were evident in the ratings of the nurses' self-perceptions of caring.

Utilizing phenomenological methods, Ray (1987) asked eight nurses in critical care "What is the meaning of caring?". Following participant observation and analysis of the interviews, she described five themes as expressions of caring in critical care: the nurses' process of growth from mastering the machinery to meeting the needs of others, technical competence, transpersonal caring that is giving and receiving, communication with the patient and the family, and conflict in relation to ethical decision making. In her study, she describes the human side of experiences in critical care nursing and describes a caring model of nursing mediated by ethical choices in a highly technological setting.

Zane Robinson Wolf (1986) developed a Caring Behavior Inventory (CBI) by selecting from the literature words or phrases illustrative of caring. Ninety-seven registered nurses were asked to rank 75 caring phrases on a 4-point Likert-like scale. The ten highest ranked caring behaviors included listening, comfort, honesty, patience, responsibility, proving information for decision-making, touch, sensitivity, respect, and calling patients by name. These actions and attitudes were considered important to the caring process in nursing.

Green Hernandez (1991) using phenomenological methods described the similarities and differences between professional nurse caring and natural caring (caring outside of nursing) as lived by twelve nurses. In the interviews, she asked these nurses to described their lived experiences of caring in both professional and personal situations. She found that professional nurse caring integrates natural caring with the expression of professional caring. She concluded that the main difference between natural and professional caring is that professional caring incorporates intentional actions derived from education and experience and that the outcome of professional caring is therapeutic for the recipient of care.

Nurse and Patient Perceptions of Caring

Several studies were found which studied both patient and nurse perceptions of nurse caring behaviors (Keane, Chastain & Rudisill, 1987; Larson, 1984, 1986, 1987;

Mayer, 1986; Rosenthal, 1992; von Essen & Sjoden, 1991a, 1991b). Larson using a convenience sample of 57 nurses and 57 patients on three oncology units in two separate studies compared the perceptions of the two groups with reference to important nurse caring behaviors. The Caring Assessment Instrument (CARE-Q), developed by Larson 1981), was utilized by participants to rank order the importance of specific nurse caring behaviors. The CARE-Q consists of 50 nurse caring behavioral items organized into six subscales: Anticipates (5 items), Comforts (9 items), Trusting Relationship (16 items), Explains and Facilitates (6 items), Accessible (6 items), and Monitors and Follows Through (8 items). Each of the 50 items is printed on a card and participants are instructed to sort the cards according to a quasi-normal distribution and in order of their perceptions of most and least important nurse caring behaviors. Larson (1986, 1987) reported that reliability of the CARE-Q was between 63% and 79% for the five least important and five most important items. Content validity was established by a panel of patients and a panel of nurses who verified the items were representative of nurse caring behaviors.

Larson (1987) reported significant differences between patients and nurses in three of the CARE-Q subscales: monitoring, comforting, and trusting relationship. The patients placed a higher value on the monitoring and follow-through functions such as 'knows how to give shots,' 'knows when to call the doctor', 'gives good physical care' and 'knows how to manage equipment.' The nurses placed a higher value on behaviors in the subscales of comfort and trusting relationship. The subscale of comfort included behaviors such as listening, talking and touching. The trusting relationship subscale allowing expression of feelings, getting to know the patient as an individual and puts the patient first. There were no significant differences on any of the other subscales.

Mayer (1986) replicated Larson's (1984, 1986, 1987) work with a different sample of cancer patients and oncology nurses. Her sample also included the perceptions of family members. Similar to Larson, she found that patients tended to rate instrumental technical caring skills higher than did nurses. Nurses rated expressive behaviors, such as listening and expression of feelings, as more important than technical skills. She concludes that nurses, unlike patients, may be assuming certain levels of technical competence and that patients may not be receptive to expressive behaviors until basic physical needs have been met. She found that the families perception of important nurse caring behaviors are: the nurse being available, being honest, keeping the family informed and providing comfort for the patient. Information about sample size, statistical findings and methods of obtaining the families perceptions are not included in her report.

Keane, Chastain, & Rudisill (1987) studied the perceptions of rehabilitation patients and nurses as to the most and least important nurse caring behaviors. Their sample consisted of 26 nurses and 27 patients. The researchers utilized the Care Q developed by Larson (1981) to obtain the perceptions of the participants. Unlike other studies of nurse caring behaviors they found higher agreement between patients and nurses. Both patients and nurses ranked nursing caring behaviors in the 'monitering and following through' and 'is accessible' as most important in facilitating patients to feel cared for. Patients and nurses agreed that the most important items were 'knows when to call the doctor' and 'puts patient first, no matter what.' It is of interest to note that nurses in this study ranked self care practices and patients' active participation over affective behaviors. Possibly this is reflective of the philosophy and practice in a rehabilitative setting.

In a cross cultural study of important nurse caring behaviors, von Essen and Sjoden (1991a, 1991b) studied the perceptions of Swedish hospital patients and nurses. Both studies used the CARE-Q developed by Larson (1981). In their first study, they administered the CARE-Q to 81 patients and 100 nurses in medicine, oncology and surgery. They found significant differences in patient and nurses perceptions in the rating of 29 of the 50 nurse caring behaviors. Patients consistently ranked instrumental behaviors which demonstrate technical competence most important. Staff consistently ranked expressive behaviors such as listening, touching and talking as most important. These findings are similar to those of Larson (1984, 1986, 1987) and Mayer (1986).

von Essen and Sjoden (1991b) reported a systematic replication and extension of their initial study on nurse caring behaviors. In this study, half the sample was given the CARE-Q to complete whereas the reminder were given a questionnaire. The questionnaire consisted of the same 50 items as the CARE-Q except participants were asked to rank the importance of the behavior using a seven point Likert-type scale. A total of 86 patients and 73 nurses, nursing assistants and nursing aides were included in the sample. These authors found significant differences on the CARE-Q in that patients gave a higher value to items on the subscales moniters and follows through and explains and facilitates. Staff rated items on the comforts subscale higher than patients. From an analysis of the questionnaire, the authors found that patients perceived clear information and competent clinical expertise as most important while staff rated expressive behaviors highest. Provision of clear information had not been previously reported as an important indicator of nurses' caring. These authors suggested that perceptions of caring of patient-staff dyads might show stronger agreement and cite this as one limitation of their work.

Rosenthal (1992) replicated Larson's work in a coronary care setting. She used the CARE-Q developed by Larson (1981) to obtain thirty patients and thirty nurses perceptions of most and least important nurse caring behaviors. She noted that both patients and nurses complained about the forced choice format of the CARE-Q. The three most important behaviors selected by patients were: knows how to give shots and manage equipment, gives treatments and medications on time, knows when to call physician. Patients considered 'the nurse being pleasant and friendly' and 'sits down with patient' as least important indicators of nurses' caring. Nurses in this study ranked listens, knows when to call physician and allows expression of feelings as most important nurse caring behaviors. They ranked doing little things and suggesting questions to ask the doctor as least important behaviors. Her findings are similar to those reported by other researchers (Larson, 1984, 1986, 1987; Mayer, 1986; von Essen & Sjoden, 1991a, 1991b). Rosenthal observed that the differences between patients and nurses might not be significant if placed in context and that phenomenological methods should be encouraged since many participants wanted to tell their own stories.

In all the quantitative studies of nurse caring behaviors, including those by Cronin & Harrison (1988), Larson (1984, 1986, 1987), and Mayer (1986), patients and nurses were forced to pick from lists of nurse caring behaviors without reference to a specific situation. In these studies as suggested by Mayer, the nurses may have assumed differing levels of competence than the patients. Also the forced choice format requires that participants must consider some nurse caring behaviors as least important. That is not to say that they are not important rather they may be less important until competency is established or may change given their current situation or the context of their relationship with the nurse. According to Benner (1989), the context of caring is essential to describing caring and expert nursing practice.

Two additional studies were found which studied the perception of caring from the perspective of both the patient and the nurse (Miller, Haber & Byrne, 1992; Valentine, 1991). Miller, Haber and Byrne (1992) interviewed both patients and nurses to obtain their descriptions of caring nurse-patient interactions they had experienced. Their sample consisted of 15 patients and 16 nurses from a variety of adult medical surgical units. In this study, the nurses were identified for inclusion by the head nurse on each unit rather than the patients. Using phenomenological methods developed by Streubert (as cited in Miller, Haber and Byrne), they derived five parallel themes of a caring interaction: holistic understanding, connectedness/shared humanness, presence, anticipating and monitering needs, beyond the mechanical. From the the five themes exhaustive descriptions capturing the essence of a caring nurse-patient interaction were developed. According to patients, caring nurses are interested, connect with you, are courteous and take time, there to help, treat you an an individual, care for you in many ways, surround you with consideration, and know which needs to met first. According to nurses, caring is a way of being, caring nurses establish relationships by building rapport, get to know patients while meeting physical needs, moniter patients continuously, and caring has positive effects such as sense of satisfaction.

In a study by Valentine (1991a), she obtained perceptions of caring for matched pairs of patients and nurses. She used both quantitative and qualitative methods to explore patient and nurse perceptions of caring. She was attempting to measure congruence between nurse patient pairs. In this study, congruence was defined "as the agreement between each nurse-patient pair about their perceptions of caring during a specific encounter" (p. 101). A Nurse Caring Questionnaire (NCQ) and Patient Caring Questionnaire (PCQ) were administered to ninety-one hysterectomy patients and their nurses usually on the patients' third post-operative day. These questionnaires were developed from a conceptual model of caring derived from qualitative and quantitative data collected from nurses, patient, managers and nursing theorists in the larger study (Valentine, 1989). Each questionnaire consisted of 61 Likert-type items which "measured the degree to which caring occurred in specific nurse-patient encounters" (p. 102). A congruence score was calculated for each nurse-patient pair from paired questionnaire items. The congruence scores ranged between -.07 and .60. The mean correlation for all matched pairs was quite low (.18). Valentine (1991a) concluded that there was little congruence between nurse and patient caring scores and that participants neither agreed nor disagreed about the caring which occurred in these encounters. She suggested that this might be due to measurement artifacts (restricted range or dropped cases) or that the measures did not accurately reflect congruence. Each participant was also asked to write a narrative about what had occurred within the encounters (Valentine, 1991a). Qualitative responses were of limited use in facilitation interpretation of quantitative data except that she did find that patients with total questionnaire scores on the high or low end were more likely to respond with narrative. As one might expect, those patients with high scores were generally positive about nurse caring, whereas those on the low end tended to be negative.

Responses to Caring

There were only two studies located that explored patient's responses to nurses' caring. Both of these studies have been described previously in this review of the literature. Paternoster (1988), asked patients in the phenomenological study how they felt when they knew that a nurse cared about them. She described their responses as falling into four broad categories: feeling good, feeling secure, feeling connected with the nurse and feeling validated. She related that patients had difficulty reaching any kind of depth in their responses.

In the study by Reiman (1986) patients were asked for their responses to caring and noncaring interactions. The experience of a caring interaction resulted in the client feeling comfortable, secure, at peace and relaxed. As a result of noncaring interactions, patients felt devalued as a unique individual and treated as an object to be manipulated and controlled. For these patients, such interactions aroused negative feelings such as frustration, fear, depression, anger. In a study by Drew reported earlier, she found similar responses by patients in relation to distressing and nurturing encounters.

In a few of the studies reported earlier, nurses' responses to caring were reported. In Ford's (1990) study, she reported that nurses were enriched by the experience but thought that nurses also needed time to recharge between caring encounters. Miller, Haber & Byrne (1992) reported that the nurses' in their study felt a deep sense of satisfaction in response to caring interactions.

Related Studies

In a related qualitative study, Drew (1986), interviewed 35 surgical patients to obtain their perceptions of distressing and nurturing encounters with caregivers. Using constant comparative method of analysis, she identified the two processes of exclusion and confirmation. The experience of exclusion was characterized by caregivers who were lacking in emotional warmth and not caring about them, were hurried and as a result disliked their jobs, avoided eye contact , had a flat tone of voice, used jargon or oversimplified language, and avoided proximity. The experience of confirmation was characterized by caregivers who had an expansive range of affect, were relaxed, looked at them, used a modulated tone of voice, did not use jargon and came close to them when speaking. Patients thought these caregivers wanted to be there, cared what happens and liked their work. The experience of exclusion resulted in feelings of fear, anger, shame and energy depletion for the patient. The experience of confirmation resulted in a sense of hope, comfort, confidence, relaxation, sense of ease, and were energizing.

Clayton, Murray, Horner and Greene (1991) conducted a study to determine the process by which caring relationships develop between patients and nurses. They reviewed the nomination packets of 70 nurses submitted for the Award for Excellence in Cancer Nursing. The nomination packets included forms and letters from patients, families, nurses and physicians colleagues of the nurse being nominated. Using grounded theory methodology, they identified five categories: environment broker, professional/expert knowing, facilitating factors, personal being, connecting. They state that connecting is the social-psychological basis for the process of developing a caring relationship. They define connecting "as the transpersonal experiences and feelings that lead to a sense of connection, attachment, or bonding between nurse and patient/family" (p. 160).

Clayton et al. (1991) have proposed the following stages in the process of connecting: presencing, attending, affiliating, and empowering. Presencing is when the patient and family with needs and vulnerabilities come together with the nurse who is aware of their needs, knowledgeable and has the personal characteristics to care for them in their situation. In attending the patient as they move through their illness, the nurse provides evidence of intent and ability to care. In the stage of affiliating the patient, having experienced the nurse's commitment and abilities, recognizes the uniqueness of their shared experiences and both embraces it and wishes to reciprocate it. As the patient and nurse move forward, they are empowered or have garnered strength and confidence from their shared experience. These authors believe that connecting is the precursor to caring.

Taylor (1992a, 1992b) in a phenomenological study of four patients and six nurses in a professional nursing unit used participant observation and interviews to explore the phenomenon of ordinariness as the human commonality that connects all people. Taylor (1992a) contends that caring is a state of being through which people "express their connectedness to one another in everyday ways befitting their relationships" and is manifested as ordinariness in nursing (p.182) . She defined ordinariness as "the sense of shared humanity between nurses and patients" (1992b, p. 33).

In her study, Taylor (1992b) analyzed 24 interactions that manifested a different aspect of the phenomenon of ordinariness. To date, she has reported interactions between one patient and one nurse which illuminated one aspect of ordinariness that of the nurse's presence and actions which were effective in providing comfort by relieving pain. This comforting encounter between patient and nurse was found to have eight qualities: Appreciating skillful nursing care, expressing feelings, acknowledging relevance of family, facilitating independence, facilitating changes, relating to the others situation, enjoying a sense of humor, preparing to go home. In her analysis, all the themes emphasized the nurse and patient as persons and the shared humanity between nurse and patient that fortifies both participants.

Some authors have suggested that more attention needs to be given to the outcomes of the process of caring (Duffy, 1992; Shiber & Larson, 1991; Valentine, 1991b). Duffy conducted a descriptive correlation study to measure the relationship between nurse caring behaviors and selected outcomes of patient satisfaction, health status, length of stay and nursing care costs for hospitalized medical and surgical patients. She hypothesized there would be a positive relationship between patient satisfaction, health status and nurse caring behaviors. She predicted an inverse relationship between length of stay, nursing care costs and nurse caring behaviors. The Caring Assessment Tool (CAT) developed by the researcher was administered to a random sample of 86 patients. The CAT consists of 100 Likert-type items scored on a five point scale. Four additional tools were used to measure the selected outcomes: Patient Satisfaction Visual Analog Scale, Sickness Impact Profile to measure health status, Medicus Patient Classification Tool measured hours of nursing care per day. She found a positive correlation between nurse caring behaviors and patient satisfaction. She cited lack of sensitive or inaccurate measures and the diversity of the sample as possible explanations for her findings. Relationships between nurse caring behaviors and the other variables were not supported. She concluded that caring nurses are related to satisfied patients and therefore are an important indicator of quality of care.

Valentine (1991b) conducted a similar quantitative study to determine the relationship between perceived caring by patients and selected outcomes. Caring was measured by the Patient Caring Questionnaire developed by the researcher and discussed previously. Three outcomes were measured in this study: patient satisfaction, length of stay, and post-operative complications. A commercially prepared patient satisfaction questionnaire was completed by 91 women following discharge after an elective hysterectomy. The measures of the outcomes of length of stay and post-operative complications were obtained by review of the chart according to pre-set criteria. She found that the degree to which caring occurred between patients and nurses as perceived by the patient did contributed significantly to the outcomes of patient satisfaction, length of stay and post-operative complications.

Summary

A review of the nursing literature on caring offers some insights into the meaning and process of caring. Firstly, there is a consensus that caring is an important phenomenon for nurses to research. Although attempts to integrate various perspectives on caring are evident, the meaning of caring is still emerging. Secondly, current research suggests that caring is universal but context dependent. This means that additional research is required in a variety of settings to determine the meaning of caring for specific groups of patients and nurses. Thirdly, concerns have been raised that the essence of caring may be lost when it is studied quantitatively. Attempts to measure caring have resulted in a loss of the unique and rich experience of caring from the perspective of the participants. Some authors have suggested that caring is best studied by qualitative methods (Dunlop, 1986; Leininger, 1988; Watson, 1988).

Some theorists have hypothesized that caring influences healing (Leininger, 1988, Parse, 1988; Watson, 1988). However, only two studies were found which reported patient responses to caring. In relation to nurses responses to caring, only two studies were found which briefly mentioned the effect of caring for nurses. In this review of the literature, several studies were located in which both the perceptions of caring from the perspective of both the patient and nurse were reported. (Larson, 1987; Mayer, 1986; Miller, Haber & Byrne, 1992 ; Rosenthal, 1992; Valentine, 1991a; von Essen & Sjoden, 1991a, 1991b). The studies by Larson, Mayer, Rosenthal and von Essen and Sjoden did not match patients and nurses and were focused on perceptions of most and least important nurse caring behaviors. Valentine's study was the only reported study found in which nurses and patients were matched. Her study was an attempt to measure congruence in perceptions of caring between patients and nurses and did not attempt to described the qualitative experience of the participants' perceptions of caring. The study by Miller, Haber and Byrne did describe the participants perceptions of caring interactions. However, no attempt was made to match or compare the perceptions of patients and nurses. No studies were found in which patient and nurses perceptions of caring were described when patients identified the nurses for inclusion in the study.

III. METHODS

In this chapter, methods used to answer the following three research questions will be discussed. The three research questions are: 1) What are the perceptions of both the patient and the nurse of a shared caring interaction? 2) What are the similarities and/or differences in patient and nurse perceptions of a caring interaction? 3) How does the perception of caring affect the patient and the nurse? Initially, a description of the study design used for this research project will be given. A description and explanation of the setting, sample, data collection and data analysis methods will follow. Since reliability and validity are important issues for reviewing this and any study, issues of reliability and validity will also be addressed. Lastly, ethical considerations applicable to this study will be presented.

Study Design

When little is known about a phenomenon and the intent of the research is to gain insight into the phenomenon under study, the design of choice should be a qualitative one (Brink & Wood, 1989; Morse & Field, 1985; Parse et al, 1985; Wilson, 1989). In this study, the intent was to obtain information about and develop an understanding of patient and nurse perceptions of caring interactions. Since little is known about the perceptions of patients and nurses of a shared caring interaction, it was appropriate to use a qualitative method for the purpose of exploration and description of the phenomena being studied

Qualitative research is an inductive approach to develop understanding and knowledge from the emic perspective which is derived from the subject's description of the experience. According to Brink & Wood (1989), if there is a lack of reported research about the phenomena to be studied it is appropriate to use a Level I research design. Since little is known about caring interactions between patients and nurses and there is a need to describe this phenomena more clearly, an exploratory descriptive Level I research design was chosen for this study. An exploratory/descriptive design was used to develop an understanding of the perceptions of caring interactions from the perspective of patients and nurses.

Exploratory/descriptive designs can be utilized for the purpose of exploring the nature of an experience which has been shared by the subjects using interviews as the method of data collection (Parse, Coyne & Smith, 1985). May (1986) stated that descriptive data differs from theoretical data in that descriptive data contains specific details and represents a first level of analysis. She concluded that descriptive research is valuable in itself and that most areas would benefit from more descriptive research.

Data were collected during guided interactive interviews. The data were transcribed and reviewed for common words themes and phrases that were descriptive of caring interaction. An inductive content analysis of patients and nurses perceptions of caring interactions was done to construct broad categories of caring interactions and the effect of these interactions on patients and nurses. The categories of a caring interaction and the effect on participants was derived from the data rather than using predetermined categories. The inductive approach to analysis served to ground the data in experience and represented the nature of reality from the point of view of the subjects. According to Swanson (1986), descriptive categories, derived from the data collected in interviews, are needed as building blocks to generate hypotheses that can lead to the eventual linking and generation of grounded theory.

Setting

This study was conducted on two thirty-six bed general surgery/gynaecological units in a 900 bed urban teaching hospital located in a metropolitan area of Western Canada. Until recently, only women requiring gynaecological surgery were admitted to these units. The type of gynaecological surgery for which patients are admitted is generally bladder repairs, hysterectomies, removal of adhesions and minor procedures such as removal of ovarian cysts and dilatation/curettage. Currently, nine beds on one unit are set aside for patients requiring general surgery. The two units are staffed by registered nurses and registered nursing assistants. Staff work full time, part-time and and there is a mix of staff working both eight and twelve hour shifts. All nurses rotate through both units. The nurse manager is responsible for the overall delivery of care on both units. A permanent day charge nurse is assigned to each unit.

The two units are located adjacent to each other. Each unit is set up to accommodate patients in either private or semi-private rooms. The design of both units is in the shape of an H with the nursing station being in the center and patient rooms on either side of centre. There is an easily accessed patient lounge, kitchen and quiet room located outside the entrance of the two units.

Sample

In a qualitative research study, it is critical to interview key informants who have knowledge of/or experience with the phenomenon being studied, are willing to participate, and can articulate their experiences in a reflective manner. Participants who meet these criteria provide a rich source of data which will facilitate the researcher to fully describe the phenomenon being studied (Field & Morse, 1985). For these reasons statistical sampling techniques are not appropriate when doing qualitative research and were not used in this study. The non-probability sample for this study was composed of nurse-patient dyads from the two gynaecological surgery units described earlier. Patient participants were chosen for reasons of convenience and experience with the phenomenon (Field & Morse, 1985; Wilson, 1989). Nurse participants were identified by the patient participants.

Recruitment of patient participants for this study was conducted with the assistance of the charge nurses of the two units. The charge nurse, in consultation with the researcher, identified patients who would be good informants and were physically able to be interviewed. Subjects were selected for their experience with the phenomenon identified for this study. The charge nurse distributed an information sheet explaining the study to potential patient participants and then inquired if they would be willing to talk to the researcher (see Appendix A). Potential participants were usually approached by the charge nurse on their first or second post-operative day. Forty-eight potential informants were approached by the charge nurse, fourteen women immediately indicated they were not interested in being involved in the study. Eleven gave no reason for their refusal. One woman refused because she stated she wanted to talk about the doctors not the nurses. In one case, the charge nurse discovered one woman was unable to read English when given the information sheet. Another woman indicated that she had not experienced caring with any of the nurses. Eleven were either unavailable on repeated visits by the researcher or were discharged before further discussion with the researcher could take place.

Participants were selected for their experiences with the phenomenon being studied. Therefore, only patients who had experienced a caring interaction and could identify the nurse with whom they had experienced caring were included in the sample. Twenty-three women were approached by the researcher. Three women immediately identified a nursing student as being caring. When asked if they had experienced caring with an RN, only one of the three could identify an RN. Four women could not remember the name of the nurse with whom they had experienced caring and were unable to give an accurate description of the nurse. Several of these women indicated all the nurses were caring and could not identify one in particular. Four women who identified a specific nurse decided not to be in the study for personal reasons such as lack of time or energy. Two women who had identified a specific nurse lived outside of the city and were discharged before they could be interviewed. One woman was moving out of province immediately after discharge and indicated she would be unavailable for the second interview. During recruitment, six nurses were identified as caring on more than two occasions by potential patient participants. In two instances, patients identified two nurses they described as being equally caring.

In qualitative studies, such as this one, the goal is to obtain rich data which fully describes the phenomenon being studied. Smaller sample sizes facilitate the researcher to obtain rich data which is detailed and comprehensive and permit data to be more easily managed (Morse, 1986; Sandelowski, 1986; Brink & Wood, 1989). Of the twenty-three participants approached by the researcher, ten woman agreed to participate in the study. All ten of these women could identify by name the nurse with whom they had experienced a caring interaction. The women who participated in this study met the following criteria:

1. Able to read and speak English.
2. Eighteen years of age or older.
3. Able to identify and discuss their experiences of nurse-patient interactions perceived as caring.
4. Able to identify a particular nurse they considered caring.

Prior to the onset of the study, an information sheet about the study was distributed to all the nurses on each unit. The nurses were requested to return the lower portion of the form if they did not wish to be contacted about this study, if identified by a patient (see Appendix B). No nurses returned the form indicating an unwillingness to participate in the study if identified. Identified nurses were contacted directly by the nurse researcher with the assistance of the nurse manager. The ten participants identified eight nurses. Two nurses were identified twice. One of the eight nurses indicated she would be unable to participate because she would be unavailable due to vacation. Therefore, this dyad could not be included in the sample. With respect to the nurses, the following criterion for inclusion was met in all cases:

1. Willingness to participate and discuss their experiences of caring in relation to the particular patient.

A total of nine patients and seven nurses composing nine patient-nurse dyads were interviewed. One patient-nurse dyad was interviewed during the pilot study and the remaining eight dyads were interviewed for the main study. All participants were women and all were Caucasian. All the patients in the study had experienced gynaecological surgery and were interviewed post-operatively. The nurses had a range of years of experience in nursing from three months to 26 years. One nurse had previous experience as an RNA prior to becoming an RN. Another nurse had returned to nursing after being out of practice for fifteen years. In Table 1 and 2 a summary of the characteristics of the patient and nurse participants is presented. Table 1 and 2 do not include data about the participants interviewed for the pilot study. Interviewing was stopped after obtaining data from the eighth dyad because no new descriptions of caring interactions were being heard (Strauss & Corbin, 1990).

Table 1

Characteristics of Patient Participants

Dyad Number	Age In Years	Occupation	Marital Status	Diagnosis	Length of Stay at time of Interview	Times hospitalized in past five years
1	52	Homemaker	M	Rectocele Repair	5 days	12-15
2	43	Store Clerk	D	Abdominal Hysterectomy	8	4-5
3	41	Librarian	D	Bladder Repair	19*	1
4	39	Self-Employed	M	Abdominal Hysterectomy	12	2
5	30	Homemaker Student	D	Abdominal Hysterectomy	7	2
6	21	Secretary	M	Removal of Ovarian Cyst	5	0
7	30	Administrative Assistant	M	Endometriosis Removal of Adhesions	6	1
8	N/A	Accountant	M	Bladder Repair	14*	2

M.= Married/Common-law; D.=Divorced/Separated

*Two admissions related to this surgery

Table 2

Characteristics of Nurse Participants

Dyad Number	Age	Level of Education	Marital Status	Length of Practice in Nursing	Length of Experience on Units	Current Position Held
1	47	RN Diploma	M	1 year	1 years	Regular Part-Time
2	23	RN Degree	S	2 years	2 years	Regular Full-time
3	46	RN Diploma*	M	26 years	11 years	Regular Full-time
4	42	RN Diploma	M	22 years	22 years	Regular Full-time
5	52	RN Diploma	M	15 years	12 years	Regular Full-time
6	44	RN Diploma	M	3 years	3 years	Regular Part-Time
7	44	RN Diploma	M	3 years	3 years	Regular Part-Time
8	21	RN Diploma*	S	3 Months	3 Months	Casual

*Has completed courses towards BSc.N

Data Collection

Guided interactive interviews with patients and nurses were the main mechanism for data collection in this study. An initial face to face interview was conducted followed by a second telephone interview approximately three months after the date of the first interview. All interviews were audio taped and transcribed verbatim. An additional source of data was the field notes kept by the researcher. Three types of field notes were kept: observational, theoretical and methodological. The purpose of observational field notes was to document nonverbal content of the interviews, the context of the interviews, and the impressions of the researcher (Field & Morse, 1985). These notes were either taped or written immediately following each interview. The taped notes were transcribed verbatim.

Theoretical notes were used to reflect the beginning analysis of the data. They contained the thoughts and beginning interpretations of the researcher about the major categories of caring interactions that were prevalent in the collected data. These notes were used during the development of categories and helped to facilitate tracing the analysis of the data during the writing of the results. Thirdly, methodological field notes were kept and contained information about the research process.

All the interviews were conducted by the primary investigator. Guided interactive interviews were used to solicit the perceptions of the participants about the phenomenon being studied. A guided interactive interview allowed the researcher to utilize a set of guiding questions designed to facilitate exploration of patient and nurse perceptions of caring interactions. The guiding questions were used at the beginning and throughout the interview and supplemented by more specific questions in relation to the responses of the informants. For example, use of open questions, minimal encouragers and reflection were used to encourage participants to expand as fully as possible descriptions of their experiences. The flexibility of a guided interactive interview ensures the fullest exploration of the phenomena being studied from the perspective of the informants.

During the initial interview, guiding questions focused on three levels of experience: a single caring interaction within the dyad, additional caring interactions within the dyad and other caring interactions experienced by the participant outside the dyad. When interviewing patients, the interview started with an open ended question such as "Tell me about a time (name of nurse) was caring." Interviews with the nurses began with a slightly different open ended questions "Tell me about a time you were caring with (name of patient)." Additional questions such as "What was this like for you?" "What did the nurse (you) say or do that was caring?" "Tell me more about that"; or "Could you give an example of ....?" were used to encourage participants to expand and fully describe caring interactions. Patients were also asked to describe other caring interactions during this and other hospitalizations using broad open ended questions such as "Tell me about other caring experiences with (name of nurse)" or "Tell me about other times (incidents) when you thought a nurse was caring." Similar types of supplementary questions to those outlined above were used to facilitate participants to fully explore these interactions. Broad opening questions such as "Tell me about other caring experiences with (name of patient)." and "Tell me about other experiences when you felt you were caring towards a patient during your nursing career?" were used during interviews with the nurses to explore other caring interactions. Clarification and validation of participants' thoughts and feelings was sought by the interviewer throughout the session. Descriptions of noncaring were explored as they arose in all interviews and were used to provide contrasting examples.

Both patients and nurses were encouraged throughout the interview to discuss their situation at the time the caring interaction occurred. Patients were also asked about their responses to caring interactions using such questions as "How did you feel when you thought the nurse was caring?" "What difference did it make to you when you thought the nurse was caring?" Nurses were also asked about their responses to caring interactions with questions such as "How did you feel when you thought you were caring? "As a nurse, how were you affected by your experiences with this patient?" Both patients and nurses were asked for their thoughts about the interview with a question at the end such as "How did you feel about this interview?" In the first interview, participants generally responded positively to the experience of the interview. Some stated that they enjoyed the interview and/or that it stimulated them to think about things in a deeper way.

Nurses and patients were interviewed separately at a time convenient to the individual participants. The initial interviews were conducted face to face with patients being interviewed prior to the nurse they identified. At the beginning of each interview, a biographical data sheet was completed (see Appendices C & D). The initial interviews lasted from 45 to 90 minutes. The face to face interviews took place either in a quiet room just outside the unit or in the participant's home. Four of the patient interviews took place in the hospital the day of or just prior to discharge. These interviews were conducted in the quiet room located outside the two units. The remaining patient interviews were conducted in the participant's home during the initial discharge period. In two cases, the patient had to be admitted a second time for complications related to the surgery, so the initial interview took place in the period following discharge after the second admission. Time for the interviews was set when the patient was unlikely to have visitors or be resting. All the nurses except for two were interviewed in their own homes. One was interviewed in the researcher's office and one was interviewed in the quiet room outside the unit at their request. When the quiet room was used, it was reserved ahead of time and an occupied sign was placed on the door to prevent interruptions. If the interview occurred in the participant's home, a time was arranged when the participant would be home alone and free of interruptions.

All participants were interviewed a second time except for one patient and one nurse. The patient had become very ill with ovarian cancer and was physically unable to be interviewed. The nurse could not be contacted because she had moved to another country. Following transcription of the initial face-to-face interviews, the transcripts were reviewed for accuracy with the audiotaped interview and a copy mailed to each participant. An additional copy of each interview was made and secured. Participants were asked to review the transcript for clarity and accuracy and information that the researcher would be calling in a few days to set up a second interview was included. Use of telephone interviews facilitated interviewing participants who lived outside of Edmonton and provided flexibility in scheduling for both the participant and the interviewer.

The purpose of the telephone interviews was to obtain verbal verification of the accuracy of the transcripts as well as participants' comments and reactions to the transcribed interview. Participants were encouraged to make notes directly onto their copy of the interview. The following open-ended questions were used to guide the telephone interview: How accurately does this transcript reflect your thoughts and feelings at the time of the interview? What changes and/or additions, if any, would you like to make to this interview? As you reflect on the interview, how do you feel about it? Additional questions for the second interview were generated from the analysis of initial interviews. The second interviews lasted from 35 to 60 minutes.

Participants generally found the second interviews more difficult than the first for two reasons. One, second interviews were conducted approximately three months after the initial interviews and in some cases the participants described feeling very removed or distant from that experience. Secondly, for the patient participants rereading their transcripts reminded them of their vulnerability at the time of hospitalization. Additionally, most patients and nurses expressed discomfort at their perceived inability to articulate themselves in the first interview.

Data Analysis

According to Field and Morse (1985) the purpose of data analysis in qualitative research is twofold. The first purpose is to code the data, so that categories may be recognized, analyzed and described. The second purpose is to develop a data filing system that is flexible with procedures for retrieving data. Following the completion of transcribing, the researcher carefully listened to the content of each tape several times for both tone and content of the questions and responses of the interviewer and participant. During the listening of each tape, interviewing skills were evaluated, and corrections made to typed copy. For example, the interviewer in some cases failed to ask for a specific example to illustrate a concept expressed by the participant. At this time, questions for the second interview with each participant were generated. These follow-up questions were focused on asking the participant to elaborate on the meaning of what was said or to give additional examples to illustrate general comments.

Morse (1991) describes a practical method for using the MacIntosh computer to facilitate the analysis of qualitative data. In accordance with Morse's method, the interviews were transcribed and placed into a computer file. Each interview was labelled with interview, subject, and page numbers. Back-up copies of the interview files were created. Back-up copies of the data were kept separately from the working copies to avoid loss of data. One hard copy of each interview was kept in a separate filing cabinet.

Coding is the means by which the data is broken down, conceptualized and put back together in new ways. The process of open coding allowed the researcher to name and categorize phenomena through close examination of the data (Strauss & Corbin, 1990). Initially, those interactions between the patient and nurse in each dyad were reviewed line by line to identify common words, themes and phrases that described the perceptions and effects of caring interactions. Initial impressions were recorded in the margin of the transcripts. Persistent words, phrases, themes or concepts describing the perceptions of a caring interaction were identified for each participant in the dyad. This initial level of analysis was used to develop descriptions of caring interactions from the perspective of each participant in the dyad.

Following description of each participant's perceptions of a caring interaction, the patients' descriptions of caring interactions were analyzed to develop descriptive categories of caring interactions from the perspective of patients. Throughout the analysis, the two analytic procedures of making comparisons and the asking of questions as described by

Strauss and Corbin (1990) were used to conceptualize and categorize the data. Similar interactions were grouped together and named. Two broad categories were then identified and named with the previously identified categories becoming subcategories. According to Strauss and Corbin, "Categories have conceptual power because they are able to pull together around them other groups of concepts or subcategories" (p. 65). A similar process of analysis was employed to develop categories of a caring interaction from the nurses' perspective.

To establish a data filing system, the researcher utilized the MacIntosh computer as outlined by Morse (1991). Notes were inserted directly into text and kept distinct by using square brackets and upper case letters. Important phrases and passages were highlighted by using bold, italics or outlining text and changing fonts. As Morse indicates, this keeps selected passages distinct even if passages overlap. Additionally, the initial notes made by the researcher were retained during subsequent analysis and development of categories.

Pilot Study

A small pilot study was completed prior to the commencement of the main study. In the pilot study, interviews with one patient and one nurse were conducted by the researcher using the guiding questions. A pilot study was conducted for several reasons. One, the pilot study provided an opportunity for the interviewing skills of the researcher to be evaluated. Following the transcription of the first two interviews, an expert in interpersonal communication provided written feedback to the researcher as to the adequacy of interviewing skills. Secondly, the researcher obtained feedback as to adequacy of the guiding questions by eliciting the perceptions of the participants. At the end of the pilot interviews, the nurse and patient were asked questions to elicit their perceptions about the clarity and adequacy of the guiding questions. Lastly, during the pilot, the researcher had the opportunity to practice obtaining consent and to become familiar with the use of the equipment. This proved valuable as the external microphone used in the first patient interview was judged to be inadequate. Therefore, this dyad could not be included in the main study.

Reliability and Validity

Issues of reliability and validity are of serious concern to the qualitative researcher. However, the criteria for assessing reliability and validity in qualitative research varies significantly from those in quantitative research. In qualitative research, the procedures for enhancing reliability and validity are to a degree determined by the chosen methodology (Brink, 1991; Field & Morse, 1985; Lincoln & Guba, 1986; Sandelowski, 1986). According to Brink, the greatest challenge to reliability and validity is posed when the researcher utilizes single unstructured or semi-structured interviews as the primary method of data collection. Issues of reliability and validity concerns will be addressed as they pertain to this research study.

In qualitative research, "reliability is concerned with the consistency, stability, and repeatability of the informant's accounts as well as the investigator's ability to collect and record information accurately" (Brink, 1991, p. 176). According to Brink, concerns with the reliability of informant's accounts when single interview techniques are utilized can be enhanced by the use of identical and alternate form questions during the interview and by transcribing interviews which can be verified by the participants. In this study, participants were asked about their perceptions and experiences of caring interactions with other nurses/health care professionals. Additionally, participants were asked to review the transcribed interviews for clarity and accuracy and their responses were recorded in a second telephone interview.

With regard to the investigator's ability, Sandelowski (1986) suggests that the criteria for reliability be that of auditability. Auditability refers to the ability of another researcher to follow the 'decision trail' of the principle investigator and arrive at similar not contradictory conclusions. In this study, auditability was addressed in the following manner. First, during the data collection analysis phase of this study, consultation with the thesis advisor was undertaken. Secondly, a nurse, external to the study with a Master of Nursing degree and experience with both the phenomena being studied and qualitative methods was consulted. As an outside expert, she reviewed the coded transcripts of two dyads to evaluate the logical development of the categories during the coding process. She concluded that, from her perception, the participants description of caring interactions was consistent with the data. She also provided feedback that enabled the researcher to refine one category of nurses' perceptions of caring. Thirdly, auditability is demonstrated by careful documentation of the procedures followed during the data collection and data analysis phases of the research. The field notes kept by the researcher during the study enhanced the accuracy of documentation. Additionally, the raw data of the tape recorded interviews have been preserved so that the findings can be verified and confirmed by other researchers.

Validity is concerned with the degree to which results represent reality (Field & Morse, 1985). Issues related to both internal and external validity must be addressed by the qualitative researcher. Internal validity refers to the degree that the researchers are actually observing what they believe they are observing. In this study, like all qualitative studies, data is obtained directly from the informants, therefore the data is grounded in the experiences as perceived by the informants, rather than obtaining data using an instrument or scale that is defined and developed from the researcher's perspective. The use of guided interactive interviews allowed the researcher the opportunity to explore the participant's perspective of the experience. An evaluation of the interviewing skills of the researcher enhanced the researcher's ability to elicit the stories of the participants.

External validity refers to the generalizability of the studies findings to the general population. In qualitative research designs, generalizability of data is limited because the purpose of qualitative research is to understand, interpret, describe, and develop theory of a phenomenon (Field & Morse, 1985). According to Sandelowski (1986), the applicability or external validity of qualitative research may be assessed using the criterion of fittingness.

Fittingness is achieved when a study's findings can "fit" into situations outside the study setting and the audience views its findings as meaningful and applicable in relation to their own experiences; and when the findings fit the data from which they were generated. Fittingness was in part determined by having one patient and one nurse not included in the study sample read the findings. The patient met the criteria for this study as identified previously. She had recently been discharged from another hospital following a hysterectomy. She stated that the descriptions of caring identified by the patients in the study were similar to her own experiences. The nurse had five years of experience working in gynaecology. She stated that the nurses descriptions of caring were really true and similar to her own experiences. Swanson (1991) states, "the validity of the findings [of a study] must be assessed by its reception. If those who have lived the phenomenon can see their own reality in the descriptions, then the validity of the findings is supported" (p. 71).

Ethical Considerations

Ethical clearance for this study was received from Faculty of Nursing Ethics Review Committee at the University of Alberta. Permission for the study was granted by the hospital where the study was conducted. Information regarding the study was presented to nurse managers and staff nurses on each unit by the researcher at a staff meeting. Information regarding the purpose of the study and the research plan were given at that time. The unit manager informed the researcher of those patients who indicated a willingness to participate in the study as well as those who requested additional information after receiving the information sheet prepared by the researcher (see Appendix A). Prior to the onset of the study, an information letter was given to all nurses on each of the units to inform them of the study and to determine their willingness to participate in the study (see Appendix B). No nurses returned the form requesting that she not be approached if identified by patient. Both the patient and the nurse were approached separately to discuss the project further. If the participant indicated a willingness to participate, the requirements of participation were explained. Following explanation of the study, a written informed consent was obtained from each party (see Appendices E and F). Participants were informed that they could withdraw from the study at any time without consequence.

Several procedures were adhered to for the protection of informant's identity. Audiotapes and transcribed interviews were kept by the researcher in a locked file cabinet. Written copies of the interview tapes were made by a typist with the tapes and typed copies identified by a code number, and all names removed to protect the anonymity of the informants. No names appeared on either the tapes or the transcribed interviews. The list of code numbers were stored in a separate filing cabinet from the tapes and transcribed interviews. In writing the results, the identity of the participants was not revealed and any material in the quotes which might disclose the identity of the participants was altered. To preserve the anonymity and confidentiality, fictitious names were used to identify both the patient and the nurse. The name of the hospital was not disclosed in writing the results.

Tapes and transcribed interviews will be kept for seven years following completion of the project. After seven years, the tapes will be destroyed. However, the transcribed interviews will be kept for an indefinite period of time. The interviews may be used for educational or research purposes in the future. Prior to using the material for future endeavor, ethical clearance by the appropriate committees would need to be obtained.

A summary of the findings of the study will be sent to all participants who requested a copy. Provision for requesting a copy of the findings was included as part of the consent form.

IV. FINDINGS

The patients and nurses involved in this study were interviewed to obtain their perceptions of a caring interaction. Patients were asked to identify a nurse whom they perceived as caring on at least one occasion. The patient and the identified nurse were asked to describe those interactions which they perceived to be caring and involved the other. Additionally, they were asked to describe interactions with other patients and nurses that they perceived as caring. Lastly, both the patient and the nurse were asked to describe the effects of those interactions.

When approached about the study by the researcher, most patient participants immediately identified a nurse who they perceived as caring. When asked, they would say "Yes, and her name was __________." When asked to describe a time the nurse was caring, several patients related a specific incident that had occurred involving themselves and the identified nurse. They were able to readily describe what had transpired during those incidents including what the nurse said or did. A few patients had difficulty recalling a specific time when the nurse was caring. They stated "It was everything N--- did" When this occurred, patients were asked to recall interactions they had with this nurse and describe what she said or did that was caring. This seemed to help patients describe times that the nurse had been caring.

Nurse participants in this study were asked to recall a time they were caring with the patient who identified them. Many nurses responded "I didn't treat P--- any different than I do anyone else" or "I did for P-- what I do for all my patients." When this occurred, the nurse was asked to describe times she had been caring with this patients as an example of her caring with all patients. When asked about times they were caring with other patients, most nurses readily related several incidents in detail. They described these interactions and their relationship with these patients as memorable or unforgettable. One nurse described these times as "indelible".

Both patients and nurses were asked to describe the effect of the caring interactions they had described. Most participants could readily describe the effect of those experience. A few patients and nurses had difficulty describing the feelings they had experienced after these interactions. When this occurred they were asked for similar times when they had experienced this feeling and asked to describe what that was like for them.

In this chapter, the findings derived from analysis of the data collected during this study are reported. The findings are divided into four sections. Presented in Part I are the similarities and differences in patient and nurse perceptions of a caring interaction. This section reports the findings in response to the research question: "What are the similarities and/or differences in patient and nurses perceptions of a caring interaction? In Part II, the perceptions of caring interactions according to each participant in the dyad are described. In this section the following research question is addressed: What are the perceptions of both the patient and the nurse of a shared caring interaction? The next section presents findings related to the third research question: "How does the perception of caring affect the patient and the nurse?" Finally, in the last section additional findings are presented.

Part I: Similarities and Differences in Patient and Nurse Perceptions

In this section, the similarities and differences in patient and nurse perceptions of a caring interaction will be addressed. A description of the similarities in patients perceptions will be followed by a description of the similarities of the nurses. A comparison of similarities and differences between the two groups is presented at the end. The findings reported in this section correspond to the research question: What are the similarities and/or differences in patient and nurse perceptions of a caring interaction? Descriptive categories of a caring interaction are reported with some supporting data. A fuller description of the supporting data for the descriptive categories may be found in the analysis of the patient-nurse dyads reported in Part II.

Patient Perceptions

Nurses' Way

The nurses' way of being and doing was perceived as caring in many interactions described by patients in this study. Several patients in this study identified that the nurses' way of being in interactions with them was caring. Some patients described the nurse as having something special. One patient described the nurse as having something extra. She stated,

> [Joan] just had that little something extra. I don't know what it is. You know, every once in awhile, there's somebody that comes along that has that little something extra. . . . She just seemed to be the one that stood out in my mind, with all the nurses that looked after me which were all exceptional nurses, she just seemed to be the one ... and I missed her when she wasn't there.

She further described this nurse as being sincere and really meaning what she said. Another patient thought that the nurse had what it takes to be a good nurse. A third patient described the nurse as having that special something when she showed more of her personal self in all her interactions. She described,

> She knew what she was supposed to do and stuff. But, I think that's what lacking ... a lot of times is that they know what they're supposed to be doing. But that overrides. It closes off the personal part whereas with her, it doesn't. You know, she knows what she's doing but she allows that personal stuff to come out too.

She contrasted this nurse with another nurse she perceived as noncaring and recalled feeling like a piece of silver that needed polishing when the noncaring nurse didn't put more of herself into giving a backrub.

Several patients described the nurse as being happy, smiling or bubbly. One patient thought the nurse's bubbly presence helped to stop her mind from overcrowding with her own worries. Another patient described the following interaction,

> It was after surgery, a few days after surgery. And she was just so bubbly and just so full of life and just made me feel good when she walked in the room. Just a smile on her face and just her attitude and the way that she presented herself. Even while she was making [the] bed, you know, you're sitting there and she's chatting away. She kind of made you feel at ease and forget that you're in pain and agony while you're sitting there and just kind of joking around. She was just ... a very bubbly person.

Other patients described the nurse as being friendly or like a visitor. One patient thought the nurse was friendly when she struck up a conversation with her during admission. Another patient described the nurse as a visitor because she keep smiling and was less formal than other healthcare providers. Another patient described the nurse as being like a friend when she discussed everything with her, was genuinely interested, and invited conversation while giving her a backrub. She stated,

> Like she just ... seemed very, you know, genuine. . . . She was in no hurry to leave. She, you know, she was actually interested. And I mean, the reason that you can tell that someone is interested is by the other competition. I mean, if they only ask you a question and you answer it, it stops there. Or if you ask them something, they give you a very short answer. I mean, it's really hard to have conversation with someone like that.

Several patients described the nurse's way of doing as being caring in the interactions they related. Some patients described the nurses' way of touching as conveying caring. One patient described the nurse's touch as sure and gentle. Another patient related that the nurse was careful whenever she removed her catheter and intravenous. She described the time the nurse removed her packing. She stated,

> She [said] to hold [my] breath. She said it might hurt a little bit when it comes out. And it did a little bit but it wasn't real bad. She was quite careful. Careful in taking it out. Kind of slow and easy.

A third patient described the nurse as being gentle, patient and treating her like a person when she started her intravenous. She described,

> It didn't bother me that she was having trouble getting this IV in. She didn't just grab my arm and keep prodding me. I was a person. I wasn't just a thing to stick this needle into.

Several patients described the nurse as treating them like a person in the way she responded to them. One patient described the nurse as always acknowledging her with a look or a smile when she would see her in the hallway. She described,

> But, if she was actually in the room or down the hall, if she saw you walk out of your room, she acknowledged that you were there. If she walked past you when you were walking down the hallway, she'd at least smile at you ... even if she was talking to somebody, she'd at least smile and the eye contact. You know, ... you're my patient and ...I'll see you in a bit sort of. . . . You get that look. . . . I don't know if you can call it a look. It just sort of acknowledges that you're not just a part of the wood work or part of the next patient ... that you have to walk in on. That you're actually a human being that's lying there and probably just as scared as the person in the next room.

She also described this nurse as always easing into everything.

> She just sort of eased you into it instead of ... making it like it had to be done now and no questions asked. . . .Like if you didn't feel comfortable about doing it right then, she'd come back for you.

Another patient described the nurse as not condescending when she provided explanations to the patient. This patient also described the nurse as taking the time to explain the advantages of going home with her catheter and finding out about her home situation. She stated, "She wanted to know what it would be like to send me home alone with the catheter. You know if it was a good idea or not. So, it wasn't just to free up a bed. . . . I think they really thought this would be best for me." She described what they talked about on that occasion,

> [She asked] if I was alone. I told her about the kids. You know having a kid at home and so she asked what school he went to. You know, that kind of chit chat. And my daughter not living at home. And then I realized after that they probably ... were trying to do is find out if I'd be home alone with this catheter. Or [if] there would ... be somebody there to sort of watch out for me.

The patient thought the nurse was treating her as an individual when she wanted to know what would be best for her and finding out her individual needs. Another patient thought the nurse treated her like an adult when she listened to her concerns that something might be disconnected, and checked them out before reassuring her.

> She just ... took my concerns seriously and checked over all the things that I was hooked up to and said, "No, I've checked them and I think everything is fine". . . . And didn't dismiss them but went through the whole process of checking to make sure everything was the way it should be. I guess I felt, that's supportive because it was ... treating me ... not less than an adult because I was a patient in bed but that, you know, under any other circumstances, if I had a legitimate concern, people would take it seriously because you're a healthy adult. But sometimes, when you're unwell in hospital, ... your status seems to be diminished from adult to patient and somehow that doesn't carry as much credibility ...

Helping Through

Virtually all the patients described nurses as caring when they helped them to get through a new or difficult experience during their hospitalization. Patients described nurses as helping them through an experience when the nurse was attentive/available, in tune with their experience or knew what they needed. Several patients perceived the nurse to be caring when she was attentive and available to them. Several patients described the nurse as always being there. They described these nurses as constantly walking by, popping in, or going in and out. One patient described,

> Like whether she was coming there to do something or just happened to be walking by. You know, it was always a wave or you know, like she'd pop in and say "Is there anything I can get for you? ... Are you okay?" You know, that sort of thing. There was nothing particular. It was ... she just seemed to be there all the time.

These nurses were always checking that the patient was okay or asking if they needed anything. One patient recalled that the nurse had checked on her frequently during her first day in hospital. She stated,

> I felt that maybe she came into the room on more occasions than she would have because I was so nervous. Just to make sure that I was okay and so I kind of maybe grew dependent on that, knowing that she'll come in to see that I'm okay.

Several patients described the nurse as being there when she was needed. One patient recalled that the nurse was there when she vomited. She described,

> I kept bugging her and bugging her and finally she brought me some juice. I said 'Well, if I get sick, it's my own fault. ' So, I drank the juice really slow and just quit for awhile and then I'd take another sip and I just drug it out through the day. And then, oh I got sick. And she was right ... there. . . . She gave me a cloth to wipe my mouth off and everything

She recalled that the nurse continued to check on her frequently after this incident. This nurse was also right there when she ambulated for the first time. Another patient recalled that the nurse was always walking past and would stop in if the patient gestured to her.

> Maybe it was the look I kind of gave her, but she just seemed to kind of stop and walk in ... instead of walking past. You'd sort of ... go like this .... I don't know ... what I did to make her think that it was something I needed. But a movement or a gesture, she seemed to pick up on the fact when you needed her and when you were just sort of busy with your own little thoughts.

This patient described the nurse as being there to fix her dressings, answer questions or reassure her. A third patient recalled that the nurse was there to give her information when she was experiencing bladder spasms. Many of the patients described the nurse being available as caring. One patient recalled a time the nurse showed her the call bell and told her to use it if she needed anything. She described,

> I'd go wander around or ... do whatever and she was always there. Like she always came in to make sure I was okay and if I needed anything. And she was just there if I needed. Well, she showed me how to work everything like the nurse's button and ... she said anything that ... I need ... just let her know and she'll be there. And she always popped in just to see if everything was okay. So, she came in and told me what time she was leaving and who was coming on and that she would be there the next day. She was just really helpful that way.

She recalled the nurse probably came into the room 10-15 times from the the time she was admitted at noon until the end of her shift at 1900 hours. She stated,

> I felt that maybe she came into the room on more occasions than she would have because I was so nervous. Just to make sure that I was okay and so I kind of maybe grew dependent on that, knowing that she'll come in to see that I'm okay.

When asked if she used the call bell , she remembered that she didn't need to use it because the nurse came in so often, had shown her where everything was and had explained so thoroughly. She described Barb as having open arms and being available for anything. She explained,

> Anything for anybody not just for myself but for anybody, she would be there to help you. And she'd do anything for. . . . Like ... she just made herself available ... and if there was anything at all that she could do for ... anyone ... she would try her best to do it. If she couldn't do it ... she'd see if somebody else could do it for you.

Another patient related that even when the nurse was busy she would check in and tell her when she would be back.

> She was always just checking in ... whether she was busy with another patient or walking past with an armload or something. She'd just kind of stop and say, "How's things going?" or "Is there anything I can get you?" And if you'd say something, then she'd say, "Well, okay, I'll be back in just a few minutes. I just have to do this." ...So, she'd explain it, you know. It would take a few minutes but she would be there. So, you weren't wondering, well how long should I wait, you know. . . . "Give me a few minutes and I'll be back."

Another patient related knowing she could talk to the nurse if she needed to. A third patient described the nurse as actually listening to her and taking time to listen. This patient perceived other nurses were not available and were not listening to her. The nurse was available both physically and emotionally by really being there when she listened and understood the patient's concerns.

> Well, lots of times when the nurses come into your room, they're there in body and that's it. I don't know whether it's because they're understaffed or if they actually hate their job that bad and it's coming through. Like I really don't know why a lot of them are like that but so many of them come into your room. They're very short with you [and] if they ask you something, they really don't listen at all. I mean, you could give them a response that's so out of character and they would never notice. You know, they'd probably say well that's good. You know? And she just wasn't like that. She, you know, she actually listened.

These patients perceived the nurse to be available physically and emotionally.

Several patients described nurses as caring when they were in tune with their experience. One patient described the nurse as being in tune with her when she removed her staples and would stop whenever she would wince.

> The second time, I was getting every other one out and [Carol] was doing it again. Now this time, some of them hurt. Some of them were put in funny or something. So when she was taking them out, they were hurting. But she was very careful to ... stop and ... give me a couple of minutes and then ... she'd go to another one and you know she was always in tune with what was happening with me. It wasn't just like well we've got to get these out. It doesn't matter how much it hurts you know. It's the unspoken respect and communication that happens, I guess.

The nurse took her time and wasn't rushing through the procedure. She thought Carol was not only in tune with her but was listening during this interaction. She described,

> I mean, all I had to do was go hhhhh! And she'd stop. I mean, because she had done the other ones and I hadn't had any reaction at all cause none of them had hurt. But she was listening to me. I could tell that because as soon as she heard me wince, she stopped. And she would, you know, she'd stop for a few minutes and she'd either go on to another one or she'd try that one in a different position sort of thing. So she was always aware of my reaction and what was going on with me. Caring enough to listen.

She also related that the nurse talked to her when she started her intravenous and seemed to be aware that this was not a pleasant experience for her.

> She was acknowledging I know it hurts. She was validating that it does hurt... That it would be over soon ... she couldn't get it in here. She said, "I'm afraid I'm going to have to try over here." And fortunately it went right in here. I don't know if it's as much what she said. She could have been saying higgelty piggelty I think. But just...that she was you know with that soothing tone again. I realize you're there. I realize this isn't a comfortable situation for you and ... just talking through. ... It was just her way, her whole way of doing it.

Another patient related several incidents in which the nurse seemed to understand her experience. She described the nurse as being able to sense her mood and follow along.

> Whether that was having my feet elevated or just not having to make small talk, because you know, in one stage of the process that seems to be what you need and [at] another point .... the day or so after the surgery... I couldn't have made small talk if I had tried, so she was very ... quiet and she seemed to ... sort of sense the mood of things and follow along with that. . . . That's what I seemed to need at that point. It seemed to [go] along with my requirements and my way of handling things.

Additionally, she thought the nurse realized how ambivalent she was about ambulating and the nurse responded by explaining and having confidence in her ability to ambulate. She also described Barb as caring when she went for her first walk

> She was the person who let me know that ... I should probably make an effort to get up and go for a walk. When I think back on it now, I think she ... realized that I was pretty unnerved by the idea of having to get up at that point. And ... I think when she realized how ... I was a little bit uncomfortable with the idea, that she ... explained ... I didn't have to go very far even if it was just to reach the chair on the other side of the room or maybe to take a few steps down the hallway and that she wouldn't obviously wouldn't send me off on my own. That ... she would walk with me if I needed or if there was a family member around that they would be welcome to do it. But that she would be right around the area and not to be concerned. Because ... I certainly was feeling that ... my bed was sort of a little safe haven. . . . I was worried about my incision.

A third patient related that the nurse seemed to understand her discomfort and uncertainty post-operatively. She described the nurse as conveying her understanding in the way the nurse attended and responded to her. For example, the nurse always seemed to be looking ahead and anticipating she might be in discomfort.

Some patients described the nurse as caring when she knew and responded to their needs. One patient described a nurse as caring when she anticipated her comfort needs by repositioning her before she asked. She stated,

> I guess because of where my incision was, it sort of made things a little less uncomfortable if you raised the bottom of the bed so that your knees were a little bit elevated. I ... was ... still in the semi-conscious state. I was uncomfortable but boy I'm not sure what would make me feel better. And she just sort of wheeled up the bottom of the bed just a tiny little bit and it sort of took the pressure off the middle a little bit differently than the pressure had been before. And ... I felt much more comfortable. Now I mean that's maybe something very obvious if you cared for a lot of people who've had ... abdominal surgery. It's one thing for it to be obvious. It's another thing for the person to just automatically ... anticipate it and do it for you. Maybe I'm not expecting too much or something in the sense that you know, I don't expect people to know all these things or anything.

Another patient described the nurse as caring when she provided her with the information she needed when she was experiencing bladder spasms post-operatively. She described,

> I think it's probably the time that I was the most emotional, maybe frantic and she [first nurse] should have calmed [me] down because I felt like I had no information of what was going on. She [caring nurse] gave it to me and that's what I needed to know. At least, I didn't have to feel so worried. . . . I thought everything was supposed to go perfect. That's what my doctor had said. And so when they didn't and nobody said anything except to say that they were going to get some medication, I wanted to know why. She [caring nurse] came and told me why. And then I didn't have to ask. She just showed up in my room and told me.

She related that the nurse explained what was happening and why in addition to reassuring her it was normal to have spasms post-operatively. Another patient described the nurse as providing her with helpful information about what progress was normal post operatively.

Another patient described the nurse as explaining everything and showing her what to do during her first hospitalization and surgery.

> She gave me booklets on the operation cause I never experienced anything like that before. ... And then she came into the room and went through the booklet with me and explained everything and answered all my questions. Anything that I didn't know she would try and answer or tell me everything she could. She was just very comforting to me.

She related that the nurse even knew to order her lunch when she had refused it previously.

> She said, "Well, ... how about I order you lunch?" I said, "Well, I'm really too nervous to eat anything I don't think [so]." But when I came back, she goes, "I ordered lunch for you anyway." She goes, "If you want you can try and eat something." She goes, "Maybe it'll calm you down or whatever." So and it did.

These nurses knew and provided what these patients needed in each of these situations.

Going Beyond

Patients in this study generally perceived the nurses as going beyond what they expected of nurses. Many patients commented that this seemed to be more than a job to the nurse or that the nurse really seemed to enjoy her job. In some situations, patients perceived the nurse to be going out of her way. One patient appreciated that the nurse took the trouble to come and visit her when she was working on another unit.

> I thought it had been nice of her to come to the room to talk to me given their busy schedule. I though that was nice of her to come out of her way to come and talk to me and reassure me. . . . Had she been the one that ... had answered my buzzer, well I would have understood that she was trying to clam me down. She came out of her way to come in and calm me down and give me some information.

Another patient thought the nurse did not have to take extra time with her when she was nervous about being hospitalized and having surgery.

> She assured me that if I needed anything or for whatever reason, that she was available for me. . . . And you know, she didn't have to do that. . . .I don't feel that it was something that she had to do. Maybe she does that with all her patients. She probably [does] cause she's the same person. It was just something that she probably .. didn't have to say. I mean, she could have said that, "Oh, anybody here can help you," sort of thing. She didn't have to say anything at all. She just made herself available for me if I needed anything. And she ... talked to me and just ... helped me to feel more comfortable in the situation and in the place where I was. And at that time, cause I was so nervous, I felt that was pretty comforting or pretty caring at that time. Cause she didn't have to take the time out to do that sort of thing cause I'm sure that she was quite busy. But she seemed to take the time because ... I'm sure she could tell that I was very nervous.

Several patients thought that the nurse was doing more than they had experienced with other nurses. One patient described the nurse as going the extra mile by taking time to listen, talk, and give her a backrub. She thought it was unusual for the nurse to spend this amount of time with a patient and thought it rarely happened.

> Just the way she was. The time she took. That she actually listened. Like my husband and I were talking about her again this morning and we both agreed that there's very few of the nurses that really seemed to, you know, to go that extra mile. . . . Just, you know, being there, listening and talking. But most of all actually really and truly listening.

Another patient thought when the nurse did things that you take for granted, she may not have gone beyond the requirements of the job but rather went beyond what she had experienced with other nurses. One patient thought it was ideal but not expected for the nurse to anticipate her needs for comfort. She related that the nurse repositioned her before she could even articulate that she was uncomfortable. This patient didn't expect the nurse to automatically anticipate her needs. Several of these patients thought that the nurse probably went beyond what was expected with all her patients. One patient described,

> Like I'm sure that she ... treats all her patients the same. That she would .. however long it takes to answer questions, do whatever, you know. That , like I don't feel that I got any special treatment from her.

On some occasions, patients perceived the nurse to be going beyond the requirements of her job. One patient thought that the nurse went beyond the requirements of her job when she put more of herself into everything she did. She described the nurse as not being afraid to put herself out there. She stated,

> [Carol] put more ... in. I mean, I know she was there doing her job but it went beyond that somehow. She put more of herself out there. Whereas this other nurse was more this is my job and there was no personal touches. . . . She considers other people's feelings you know? Whereas, with the back rub, I didn't feel that I was being considered much at all. . . . Well, I guess ideally no but from my experience, yes, if that makes any sense.

She described Carol as going beyond what she had experienced with other nurses when she put more of herself into the job. Another patient thought the nurse went beyond the requirements of her job when she treated her like family.

> She was very competent, the same as all the other nurses. But I really got a feeling that she was concerned about not just ... meeting the requirements of what was the medication that I needed or these were the orders that she had to follow from the doctor. But she was very concerned about how I felt and was I comfortable? And she seemed to sort of go beyond for lack of a better way of putting it. Sort of the way you would expect your family would care for you when you're not well.

Nurse Perceptions

Establishing a Link

Several nurses described themselves as caring when they established a link with the patient. One nurse described being friendly to put the patient at ease and help her feel more comfortable with the nurse. She stated, "That she belongs. Well, not really belongs but not afraid to ask questions. To feel comfortable talking to me. . . . Feel ... at ease, not all tense and nervous." She described putting her at ease by introducing herself and smiling. Several nurses described talking or conversing with the patient to get to know her and develop rapport. One nurse described,

> And then we ... got into, you know, how you work so hard to keep yourself in good shape and .. she said, she worked out a lot. So, we started talking about working out. You totally forgot that I was in there to do the dressing change. It wasn't "Hi, nurse", "Hi, patient", this is the procedure I'm going to do. It got to be more of a personal, like a friend conversation. So we ended up talking about working out and then I commented on how gorgeous this nightgown was that she was wearing.

Other nurses described talking about family, work or concerns to establish a relationship with the patient. Some nurses described finding a common ground with the patient through talking about shared interests. One nurse described finding a common ground with the patient by sharing experiences as mothers.

> Well, basically encourage her to talk about herself and if they are interested, if they ask questions, you share yourself as well...sometimes you can find common grounds with people in terms of family, kids, jobs. So, basically it's just a sharing of information. . . . Like being mothers gives you something similar you've gone through together. . . . You know, similar experiences. If you ... have little people or teenagers or whatever. . . . We had daughters that were very close in age. She

> had an older son that was older than my son but...still a teenage boy. . . . Sometimes we'd talk about what the kids do or that kind of thing.

She recalled that she had to make a point to establish rapport with this patient. She described this patient as being a private person. She explained, "Initially she just didn't say very much. You know, some people will automatically just talk, talk a lot. But with her, it took awhile to say something cause she seemed to have to establish a trust before she'd say anything." She recalled making an effort to get to know this patient.

Several nurses described sharing something personal about themselves to establish a link with the patient. One nurse recalled sharing she had a friend with rheumatoid arthritis.

> [Laura] has rheumatoid arthritis. And I have a friend who has rheumatoid arthritis. Actually it's ... a very good friend of mine's sister. . . . We grew up in the same town and she's had a bad experience throughout and she's handicapped ... to a point that you know she's not living a normal lifestyle. And here's [Laura]. ...you'd never know that she had rheumatoid arthritis. And me sharing that I have this friend and that she hasn't had good experience with doctors just opened something up in [Laura] and she told me all about the details about how she's coping with her rheumatoid arthritis and the importance that the doctors play because ... the direction of your care is co-determined by you and your doctor.

This nurse related that she tries to find a link, something in common, with all her patients and that establishing this link often leads the patient into talking about her anxieties. With another patient she described sharing some information about her children. Some nurses described sharing limited amounts of themselves. One nurse stated,

> Something that you can talk about that you both have in common ... but don't tell them gobs of stuff about yourself in that area. Just tell them a little bit, enough ... to be able to [develop] a trusting relationship. I think that's what it does. And then after that, hear them out.

One nurse related that she only shares enough of herself to establish trust since the patient is the focus of the interaction. Other nurses related sharing about themselves to the extent that the patient is interested. One nurse described responding to the patient's invitation to converse when the patient asked the nurse questions about herself. She stated,

> With her you could tell she was interested in more than just ringing her bell when she needed something because she would talk and she would initiate conversation that was totally unrelated to work. So, you just know that's the indication that they're interested in something other than their incision. And they're interested in you as a person. She was interested in me as a person. And obviously, that's easy to respond to when it's like an open invitation to converse.

Several nurses recalled that developing this link guided or helped them in caring for the patient. One nurse commented that developing a link facilitated knowing the patient and her specific needs. "You're establishing rapport with the patient, establishing trust with her. You're finding out what her needs are and then meeting [those] needs. . . . You ... find out more about them." Another nurse related that developing a link with the patient led to her asking questions about her surgery and recovery.

> I mean that always leads to other things. And she would think of something else ... things that you know ... she would have wanted to ask her doctor when he was in, but they just kind of breeze in and how you doing? . . . And she would, at least I got the impression that she felt confident and safe almost in asking me because we had developed that better or more personal link between us almost. So, she would ask me a few different things you know, about oh, her recovery and when is she going to be able to work out again. And what should she do, what shouldn't she do? And oh, ... "I have this to go to in a few weeks. Do you think it'll be okay if I do that?"

Another nurse related that sharing she has a friend with rheumatoid arthritis facilitated the patient sharing her experiences with the same disease. This nurse recalled that having this information helped her to provide individualized comfort measures post-operatively.

Nurses described themselves as caring when they established a link by conversing with the patient, finding a common ground, or sharing something personal. They described that this link facilitated the patient to ask questions or share more about themselves. Nurses thought that developing this link established rapport, trust and helped them to know the patients and their needs better.

Responding

Nurses perceived themselves as caring when they responded to the specific needs of the patient for information, reassurance or comfort. Many of these nurses responded to the patients' needs for information, reassurance or comfort after picking up on expressed cues from the patient. One nurse described helping the patient to reposition herself when the patient verbalized her discomfort post-operatively. Another nurse described sorting out the patient's concerns about her catheter clamping routine after she asked questions. She stated,

> She explained she had this surgery and that she's come back and she has these infections. But, ... she knew how to deal with her catheter, her clamping and unclamping. She understood what she was doing. It wasn't like she was always asking well what should I do ... [being] really unsure. She'd ask me something and I'd give her an answer and that was it.

Another nurse recalled that she provided the patient with more information after her recovery when she began asking questions during a dressing change. She described,

> Some patients, ...they're not interested. You'll say "Oh your incision's healing up really nice" and they'll say, "Oh good." And that's it. So, you know that they're not the type of person who really cares if their incision heals up or if you're going to see their scar or anything. Which is fine. There's absolutely nothing wrong with that. But then when you get somebody who is concerned and is curious then

> there's more information you can give them and so you ... take your cues from them basically.

Two other nurses described providing information and reassurance in response to patients' expressed anxiety about surgery and impending procedures. These nurses were alert, sensitive and responsive to cues that indicated the patients' needs.

Several nurses, in addition to picking up on cues from the patient, responded to the patients' needs by listening and being aware of the patient's experience. One nurse related that she provided information to a patient when she was experiencing bladder spasms after gaining an understanding of the patient's experience by working through her concerns with her.

> [Beth] was having some really bad bladder spasms and she had no idea what they were. I was in charge at the desk at the time and I went in and tried to work through why she was having the bladder spasms. There's ... a new article out regarding ... the bulbs [if they] aren't filled enough that they can give more problems with the bladder than if they are filled to capacity. So we checked to see if it was full or not and if it had the proper amount in. And as it was, it didn't help but we tried that and just asked her questions as to when she was having the pain and how it was bothering her and whether she needed to go on some relaxants to help control the spasms. And basically she just was really uptight and sort of knew what was happening but didn't really have a full comprehension of what was happening as far as her bladder was concerned. When you have bladder surgery, your bladder has to take its time to heal and..she couldn't understand why she...had this pain all the time.

She was also aware that the patient had been experiencing ongoing problems voiding and was frustrated because things were not working as she anticipated.

> She was ... really trying hard to do what she thought were the right things and she was doing the right things but it wasn't working for her. And so,... we just talked

> back and forth, the two of us and... she'd break into tears and I'd just tell her that was okay. There's nothing wrong with a few tears to let it get out.

The nurse responded by reassuring her she was doing all the right things. Another nurse provided information and reassurance to a patient after hearing that this was the patient's first hospitalization and that she was anxious about having surgery. The nurse described herself as caring when she walked this patient through what to expect in relation to hospitalization and surgery.

> Like it ... wasn't that she was worried about one particular thing. . . . It was just being in this situation. Like this was new. This was happening to her and she just needed to be walked through it kind of.

She described what she meant by walking her through.

> When we prepare ourselves for a new situation or something that's ahead of us, you know, we mentally prepare ourselves. And she hadn't been able to mentally prepare herself because she hadn't known what to think about. Like it was just something that was coming and it was one big unknown. . . . We have so many tools to do that now, like with a pre-op teaching book, and you know, just step by step going through it and letting her know that these are the things that would be happening.

She described dealing with the patient's fears by letting the patient express and putting aside illegitimate fears and letting her other fears be.

> She didn't express a lot of fears so I didn't make a big deal out of it. I didn't go into detail you know about, ... that anesthetic is risky or anything, just hear her out and if ever I sense there's something where I can calm a fear or help her put it aside, I do. And if I feel it's something that is normal and she can live through the night, I just assure her that we're there to help her. I think that's what I do more. [It's] "the things that are hard and that you are worried about, we're here to help you."

A third nurse was aware of the patient's fear of having any kind of procedure done. This nurse was constantly aware of the patient's experience and described giving ongoing explanations, and not hurrying, and giving her time whenever she cared for her, particularly when doing procedures. She stated,

> She was, right from the beginning, afraid of these drains, number one. And also of how they were going to come out, when they were going to come out, was it going to hurt, what did they do in there, and why were they in there in the first place. . . . So you basically have to explain ... why it's there. It's a relief to your system for this drainage tube to be gathering up this material that your body doesn't have to physiologically reabsorb and ... if I remember correctly, she just wasn't that comfortable with them or with anything about them really. So ... it was sort of ... an ongoing thing. . . . Even if you're just changing a dressing, you go over a lot of the patient teaching without formally going through patient teaching. I think that is probably quite comforting to the patient .... I have had several people say, "Well you're the first person that's actually sat down and explained this to me" ... and that to me, is just part of doing. And I ... feel it's an important part.

One nurse described being constantly aware when positioning that the patient had rheumatoid arthritis. She stated, "And [I] repositioned her and rubbed her back and you know, put the pillow there just [so]. I was always aware that this body has rheumatoid arthritis." She described listening and being aware of the patient's experience.

> She kept apologizing for being a burden or being too vocal about her pain and I just kept saying, "Shhh, I don't want to hear that." Cause I don't feel she was overreacting at all but she has been in control of her pain for so long and now she was dependent on someone else. And I think she felt that every time she expressed that it was painful that maybe she shouldn't be but she was moaning and then in the end, she said "Oh, I'm sorry!" Something about, "I apologize." And she's not that kind of person. . . . She didn't feel good that she was moaning with the pain. She

> felt ...she had been too vocal about her pain and so I think she said it twice. And I just said, "I don't want to hear you say that. just, shh, don't even talk about that." And... then I kept reassuring her that she had done just fine and that she was doing really well. And she was, like moving in bed the way she was after surgery. And I knew it was painful for her. I didn't want her to apologize for making me aware of her pain. . . . I knew her well enough that I could do it in a joking way like.. "Just hush up." (laughs) "Don't say another word". . . .And I needed to know when she was in pain. That's the only way I could take care of it.

Her awareness of the patient's experience of having rheumatoid arthritis also made her particularly attentive to signs such as moaning which migh indicate that the patient might be experiencing pain.

Some nurses, in addition to picking up on cues and being aware of the patients experience, were able to anticipate the patient's needs by being aware of past experiences with other patients in similar situations. One nurse recalled that she provided information about what to expect after a hysterectomy knowing the kind of information that the patient would need given her age and marital status.

> In the discharge teaching, I spent quite a bit of time with her going over what to expect, how she should expect to feel and ... if she's comfortable with herself before surgery, she should be comfortable with herself after. And like probably more comfortable because she wouldn't have the pain. She didn't seem to have a hangup about loss of sexuality or anything with having had the hysterectomy. But she did have some concerns about her sexual activity after surgery. And I imagine, because of her age, that this was quite important to her. She was ... really quite young. So I just reassured her about her body after. That she would be probably far more comfortable than she had been for a long time. And that she could expect to feel better than she had felt before.

She related that other women in similar situations have appreciated similar kinds of information. Another nurse provided the patient with information and reassurance that she was progressing normally after bladder surgery since she was aware that patients are often not told about the possibility of experiencing bladder spasms post-operatively. She stated,

> I basically told her that ... she was more the norm in that case than the abnormal. And that ... a lot of people aren't told that they're going to be in for the length of time they are and they aren't told that they're going to have difficulty [voiding] and everything afterwards. And that maybe they need to know more about being told that that's a possibility and so they don't worry about oh, I'm not doing the right thing or this type of thing. Cause I had told her she was doing all the right things that she could .. It was just a case of, you know, you're one of the people who your bladder isn't ready to do its thing yet.

One nurse commented that being new she often doesn't know what usually happens with patients and finds it difficult to provide patients with all the information. She related that she usually checks with a nurse who has more experience. "I always resort to asking another nurse with more experience to make sure I'm not giving her false information." She explained that being a new nurse she's not always sure what usually happens in similar kinds of situations with patients. A third nurse described going beyond normal comfort measures because she knew from the experience of working with other patients with rheumatoid arthritis the importance of managing her pain and keeping her mobile to avoid distress later.

> I know it's important with all the patients [but] ... especially ... with the rheumatoid arthritis patients. I knew that the comfort things were the most important because taking care of those would avoid extreme distress later. I know if it [the pain] got out of control it would be very stressful."

She knew Laura would be compromised post-operatively because of her condition and used comfort measures to relieve her pain.

> I knew how compromised she was as far as pain went. . . . I didn't wait very long to give her her fist dose. And as soon as four hours were up, I ... woke her to give her second dose. And I think that really stood out in her mind that I cared enough to find out that part of her health history. . . . I gave her a post-op sponge almost immediately after she came back because ... like the longer she stayed still, the harder it would be for her to move. The less anesthetic there would be in her system. It would be easier for her if I did it right away. I just did it right away and then ... did all the measures I could to keep control of her pain.

Another nurse related that she knew when a patient has a radical hysterectomy and an uncertain prognosis, the patient was probably feeling uncertain and unsure. She stated,

> I know it was probably on her mind but she really didn't talk about her diagnosis or anything like that. We never got into that. Because basically, ... we really didn't have anything from the doctor to discuss. Although, it was probably on her mind. . . You know, when you have a patient, I guess ... who has come in who's diagnosed with a certain type of cancer and they've come in for a radical hysterectomy which she had done, you know that they [have concerns]. Until the doctor has actually discussed with them their pathology report and the plans, I usually ... don't get into it unless ... the patient tells me that they are really worried about the results of their test you know? So basically all I can be is supportive of what's happening right now until we get to that point. Usually, I leave it for them to bring up if they're concerned about it.

She described responding to this patient by letting her bring up the topic and making her self available for whatever the patient might need, including meeting physical or emotional needs such as talking. It seems that these nurses have the ability to reflect on past experiences with other patients in a way that informs their current practice.

Doing for Everybody

In responding to the patient's needs, these nurses perceived themselves as doing for this patient what they do for all their patients. In fact, several of the nurses were unaware that the patient had perceived them as caring. Four of the nurses were surprised that they had been identified as caring by the patient. One nurse described,

> She said to me she was a very private lady. And I know the other girls have remarked that ... she's kind of hard to get to know. So, that's why it surprised me she thought I was caring because I didn't feel that ... she had perceived [me] that way.

Some nurses related that were unsure what they did that the patient would perceive as caring since they had not been aware that the patient had thought they were caring. Other nurses were aware that the patient had perceived their caring and described the interactions that they thought the patient would describe as caring. Many of the nurses commented that they did not do anything different for this patient than they do for all their patients. One nurse described her caring as the usual post-operative care. Another nurse stated, "Just almost as part of my routine ... I want them to know that I'm there for them. But then there's other times where I go out of my way to even make it more so because I might sense that need." She described,

> Like everyone gets my best care as much as I [can]. So that was probably just what I would do for any patient on any given day. Whereas there's other patients that I know they need more. More of my time. More of my support. And I spend that extra time with them as part of their [care]

The nurse recalled that the patient who identified her did not require anything extra or any emotional caring. She described,

> She wasn't showing that she had this need to talk or that she was being neglected in any way throughout her stay. She was like very confident. She seemed very ... sure of herself. ...When I came in the room, I did what I had to do. And it was

> like she didn't need me there. Not that she was pushing me away but I could tell that she was okay with what was going on. She didn't need me to explain things or ... answer any questions or really so when I chatted with her, it was just chatting. I didn't go away thinking oh I'm really glad I did that. I made a difference. Because I thought ... she's fine. There's no problem she seems to be having. I mean other than her physical bladder problem. But I mean problems, like emotional problems, resulting in that kind of thing.

Another nurse stated,

> I feel I treat them [patients] all the same. And if they perceive it as ...caring, it's more the way they respond because I feel like I go out to everyone the same. . . . I feel like my whole experience with [Megan] was caring.

Many nurses differentiated their experiences with these patients in their descriptions of caring with other patients. When asked about other times they had been caring with patients, these nurses often described situations in which there was a dramatic need for caring, such as when working with a patient who had experienced some kind of traumatic event such as an abortion, or who was acutely ill or dying. One nurse thought the experiences she described were the ones that the patient would have thought of as caring. She did not recall this patient experiencing any unusual event or crisis. She stated, "Vivid in my mind are those other ones ... where there was a crisis." She defined her experiences with these patients as "indelible." She described, "They'll never be removed. They'll be there for as long as I am, I think. As long as my memory is with me, I'm sure that those will be with me too." When asked what was different about these situations she said,

> ...The more indelible ones are the ones where there seems there was an uncaring situation that sort of allowed it to get to the point where it did. And then to get these people through ... just to reassure them is where the caring part comes in. Just to comfort them and try to work their way through it.

Some nurses described having more emotional involvement or a longer term relationship with those patients than with the patients who identified them for inclusion in this study. One nurse related,

> I treat all my patients that way. . . . I like to sort of get to know people and you know, not just treat their condition. I like to get to know them as much as I can when I'm looking after them. And if you're at the desk, sometimes you ... have an overall view of every patient on the ward but you don't know [them]. And it happened I had looked after her a few days ... on a one to one basis as her own nurse. And so I knew her better in that respect.

Many of the nurses in this study described caring interactions in which they responded to the patient's needs for information, reassurance or comfort by picking up on expressed cues, listening and being aware of the patient's experience and by anticipating the patient's need. Nurses perceived themselves as caring for these patients the way they care for all their patients.

Summary.

The perceptions of caring interactions described by patients and nurses in this study illuminated some similarities and differences. Patients perceived the nurses' way of being and doing as important to their perceptions of caring. Many of the interactions that reflected the nurse's way were, as one patient described, "significant insignificant events." These interactions were perceived as indicators of caring and the patients often described the nurse as treating them like a person in these interactions. For nurses, their way of doing and being seemed to be integral in their responses to patients and did not emerge as a specific category in the analysis. Nurses perceived themselves as caring when they established a link with the patient. Often this link was established through personal conversation and sharing of self. While patients did not describe the development of a link as important to their perception of caring, they did describe the humanness of the nurse as important to their welfare. Many patients mentioned that the nurse was caring when she was friendly or conversed with them. For the nurses, establishing a link was important because they thought it made it more comfortable for the patient or it enabled them get to know the patient and their particular needs.

Patients perceived the nurse as caring when she helped them through a new or difficult situation and this bears some similarity to the nurses' category of responding to patients' needs. There are both similarities and differences within these categories. Patients perceived the nurse being attentive and available as contributing to their perceptions of caring whereas this did not emerge as a category representative of all nurses perceptions, even though a few individual nurses mentioned that checking on the patient was important to their individual perception of caring. The most striking similarity is the congruence between patients' and nurses' perceptions of caring when the nurse is in tune with the patient's experience and responds to that experience. Patients felt that the nurse was in tune with their experience and the nurses were listening and responding to that experience. If one examines these categories closely, the caring interactions included here are those of matched patient-nurse pairs. The most obvious difference between patients and nurses in their perceptions of caring interactions in this study is that patients frequently perceived the nurse as going beyond what they expected whereas the nurses perceived that they were caring for the patient the way they are caring of all their patients. The nurses describe themselves as providing different caring for those patients who are acutely ill or in crisis.

Part II: Descriptions of Shared Caring Interactions

Perceptions of caring interactions, from the perspective of the one cared for (the patient) and the one caring (the nurse), are reported dyad by dyad. The themes for each participant in the dyad are described. A summary is given at the end of the description of each dyad. A table summarizing the themes for all eight dyads can be found at the end of Part II.

Dyad #1

Patient Themes

The patient in this dyad described Mary, the nurse she identified, as caring when she was right there. She stated, "She was there practically all the time... She was right beside me all the time, all the way." and "The day that I came back from surgery, ... she was right there every minute. You know, she'd go out and then come right back..." She described the nurse as being steadily in and out of her room. She recalled that Mary was right there to do things after her surgery. She described,

> ...She was really right there and really helped me. . . . She took all the packing and everything out. And then she got me up right away and had me ... walk down the hall a little ways at [a] time, until I [was] not so woozy.

She described another nurse as not caring when she didn't get her roommate up and walking after surgery. She believed that this nurse getting her up to walk helped her to recover after surgery. She stated, "She got me really going mobile. And ... I thought that was just great. Because like I say, I think I was out earlier than I probably should have been ... under normal circumstances."

She also described Mary as caring when she was right there all the time not only to do things but to tell her what to do. She stated,

> Like she told me to get up and walk around as much as I could. And she also gave me a little bottle that you use lukewarm water to wash yourself off before you go and after. And that's helped a lot.

She recalled that the nurse also showed her the sitz bath and "everywhere to go for everything."

She described Mary as being right there when needed. She stated, "When you really needed her, she was right there. You don't find that with a lot of nurses. You know, being there when you need them all the time." She related the following example of a time the nurse was there when needed after surgery. She stated,

> I kept bugging her and bugging her and finally she brought me some juice. I said 'Well, if I get sick, it's my own fault. ' So, I drank the juice really slow and just quit for awhile and then I'd take another sip and I just drug it out through the day. And then, oh I got sick. And she was right ... there. . . . She gave me a cloth to wipe my mouth off and everything

She recalled that Mary was right there to make sure she was okay when she vomited after surgery and when she went for her first walk. She stated, "When I first got up I was quite woozy, but she was there to make sure I was okay and she walked down with me the first time a little ways and then back to the room." She recalled another time the nurse was right there making sure she was okay. She stated,

> Then I walked over to [see] their son that had the open heart surgery. I walked over to them and visited him for awhile and then I walked back. So she said 'Now, maybe you should lay down and have a little rest.' She said, 'I think you might have overdid it today.' So she was quite caring and ... she didn't want anything to go wrong or anything to happen to me I guess."

This patient also described Mary as being right there to talk and joke with her. She stated,

> I had somebody there, somebody to talk to. Like I say, my husband couldn't come and I didn't get depressed... Sometimes, when I was in the hospital, he couldn't be there, then I was quite depressed, quite lonesome, upset. But like I say, she

> was right there joking with me and talking.... So, I just didn't have time ... to get lonesome or depressed.

When asked what they talked about, she stated, "...Just ... mainly how I felt and different things like that ." When asked about a time they joked, she replied, "We'd tell each other jokes once in awhile. So, that kept me going. Kept my spirits up." She was unable to relate the specifics of her conversations with this nurse.

She contrasted this nurse with another nurse who she perceived as not caring when she wasn't there. She described,

> Well, she just came in when she really had to. Like to take your temperature and that and then she'd take off and you wouldn't see her. And then, at bedtime, usually the nurses come around and they ask you if you need a back rub and she didn't even do that. And then we went to bed and then nobody came into the room. I'm sure of it. . . . You know, there's nobody there to help you do anything or if you need them. She just wasn't there. Wasn't there at all. She wasn't caring.

She described the nurse as caring when she did things carefully. She described the time the nurse removed her packing. She stated,

> She [said] to hold [my] breath. She said it might hurt a little bit when it comes out. And it did a little bit but it wasn't real bad. She was quite careful. Careful in taking it out. Kind of slow and easy. So that worked out good.

She also described the nurse as being careful with her intravenous when she ambulated her. She stated,

> And she was quite careful with my IV. They had to put it in my foot cause I had so many antibiotics intravenously [that it] burn[ed] all my veins up. So, the anesthetist had to put it in my foot. She kind of kept an eye on that to make sure it didn't go interstitial or come out or anything. She kept checking on it all the time.

She related that she really like this nurse and thought she was an excellent nurse. She stated, "She's just a caring, loving person. . . . [She's] a real caring nurse ... and there should be more like her." She described this nurse as being right there to do her job. She described, "To do the job that [she's] there for. You know, to help people out and try to help them to get on the way to being healed and that." This patient thought that her interactions with this nurse helped her to heal faster after surgery. She stated, "And I think this is what has helped me heal so fast because she was right there with everything to tell me, everything to do and everything."

Nurse Themes

The nurse described herself as caring when she tended to this patient's individual needs after surgery. She stated, "...Treating her as ... an individual. . . . by tending to her needs that she needed at that time. You know, like ... to make sure she didn't have pain and that she was comfortable and I checked on her frequently to see that she was okay." She recalled what she did to make her comfortable. She stated, "Rolling the bed up was one. Like she wasn't quite comfortable, so we rolled the bed up to get her more comfortable and ... well, I guess getting the ice chips for a dry mouth." The nurse also thought giving her a post-operative sponge helped to make her more comfortable. When asked, the nurse described how frequently she checked on this patient, she stated,

> Well, the first hour, you check every 15 minutes because you're taking the vital signs and ... then ... you're taking vital signs ... every half hour for the other two hours. And then every hour for another couple of hours. In between, you just go in and check to see if they're okay.

She described checking on this patient, "Well, I asked her how she was doing and if she was comfortable and if there was anything I could do for her." She related that she also asked her if she was in any pain, but couldn't recall if she required an analgesic when she checked.

This nurse also described herself as caring when she talked to the patient about her concerns. She recalled that this patient had been experiencing repeated staphococcal infections as a result of past neurosurgery and that she had been sent for a skull x-ray during this admission. She described,

> Well, I did sit down with her before surgery and talk to her about her past experiences with ... infections in her head. I don't know if anybody else had talked to her about that and how she was coping with it. And, you know, then ... after surgery, I didn't have her as as a patient, but I still went to talk to her to see how she was doing. So that carried the concern, you know the caring matter over, even though she ... wasn't my patient after.

The nurse also described herself as caring when she told the patient she explained when she was busy. She stated,

> You know, there's lots of times that you want to do extra things that you just don't have the time to do. You know, and you can explain that to the patient. Well, like I did have another post-op that day too. And like I said, she wanted something ... and I told her that I would be back. That I had to find some ice or something. I'm not sure if it was ice or what it was. But that I did have another patient that just came back from the OR [and] that I would be back after. And I did come back afterwards.

The nurse related that she always tries to give the patient a time when she will be back and then tries to be back in that time. She stated, "I'll give them a time. You know, I'll be back in 10 minutes ... and try and be back in that time."

She also described herself as caring when she made the patient aware of what was happening. She recalled a time she explained. She stated, "Well, the deep breathing and the purpose of it. She was nauseated and I told her to take a couple of good deep breaths and that cleared it away." She related that the patient was concerned about the pressure she was feeling as a result of the vaginal packing and that she explained it was normal to feel the pressure until it was removed the next day.

The nurse described herself as caring when she tried to put the patient at ease. She described what she meant by putting the patient at ease. "That she belongs. Well, not really belongs but not afraid to ask questions. To feel comfortable talking to me. . . . Feel well at ease. Not all tense and nervous." She described putting her at ease by being friendly. She stated, "Well introduced myself to her (by) my first name and smiled."

This nurse thought that what she did for this patient was similar to what she does for all her patients. She described what she did as the "usual post-op procedures." She believes she is caring with all her patients and felt that she shows interest and concern with everyone. She stated, "You're concerned with all your patients that come in. You know that they're going to get better and go home."

Summary.

This patient described the nurse as caring when she was right there. She described the nurse as being right there all the time, to do things, to tell her what to do, when needed, to make sure she's ok, to talk and joke. She described her as being careful whatever she did. This patient perceived this nurse to be there to do her job and thought her interactions with her helped her to heal.

This nurse described herself as caring when she tended to the patient's individual needs. She described tending to her individual needs by making the patient comfortable and checking on her frequently. She also described herself as caring when she talked about concerns with the patient, when she explained and when she came back. Lastly, she described herself as caring when she put her at ease by being friendly. She described herself as caring the same as she usually does for post-operative patients.

Dyad #2

Patient Themes

This patient described Pam, the nurse she identified, as caring when she chatted to her in a bubbly way while she was working. She described,

> It was after surgery, a few days after surgery. And she was just so bubbly and just so full of life and just made me feel good when she walked in the room. Just a smile on her face and just her attitude and the way that she presented herself. Even

> while she was making [the] bed, you know, you're sitting there and she's chatting away. She kind of made you feel at ease and forget that you're in pain and agony while you're sitting there and just kind of joking around. She was just ... a very bubbly person.

When asked if she recalled what they talked about during this time, she stated, "Not really. I was on morphine. It was really crazy. I lay there and the days went by, you know." This patient had difficulty recalling any more of this interaction. She stated, " I wish I could remember some of those days cause they are kind of blurry."

She remembered having the impression that Pam really wanted to help. She stated, "Just so bubbly and ... full of life and wanting to be really helpful." She described Pam as someone who enjoyed her job and contrasted her with other nurses. She recalled,

> You know, I really admire all of them but some of them just come across in a different manner where they care but they just don't show it. They're just ... doing their job and that's about it.

The patient seemed to think that the nurse was not just doing her job, she was doing more by showing she cared.

Nurse Themes

The nurse identified by this patient described herself as caring when she conversed with Connie in a personal way. She described that time,

> I remember once going in to do a dressing change on her. And we started talking about how she wanted to see her incision because she was worried that it was going to be a big incision. And we got into how it's barely going to scar and it's down so low you're not even going to be able to see it and whatever. . . . And then we ... got into you know how you work so hard to keep yourself in good shape and .. she said, she worked out a lot. So, we started talking about working out. You totally forgot that I was in there to do the dressing change. It wasn't "Hi, nurse", "Hi, patient", this is the procedure I'm going to do. It got to be more of a personal, like

> a friend conversation. So we ended up talking about working out and then I commented on how gorgeous this nightgown was that she was wearing. It was this purple satin nightgown. I said,"Oh, is that ever gorgeous!" And she said this has matching underwear too. And of course, I'm changing her dressing and so she shows me her matching underwear. So, then we started talking about where she bought it and the good deal that she got. And we got into both of our ...fetishes for lingerie and how we love shopping for lingerie and all that.

The nurse described she and Connie were talking person to person rather than nurse to patient during this interaction. She related that they clicked and their "personalities kind of meshed" as they were talking. She described, "You just know that you immediately click and you just get along well. You can joke around with them and talk about other things besides the weather." She thought that a more personal link had developed between them and that lead to the patient asking questions about other things while she was changing her dressing. She described,

> I mean that always leads to other things. And she would think of something else ... things that you know ... she would have wanted to ask her doctor when he was in, but they just kind of breeze in and how you doing? . . . And she would, at least I got the impression that she felt confident and safe almost in asking me because we had developed that better or more personal link between us almost. So, she would ask me a few different things you know, about oh, her recovery and when is she going to be able to work out again. And what should she do, what shouldn't she do? And oh, ... "I have this to go in a few weeks. Do you think it'll be okay if I do that?"

She recalled that Connie seemed interested in receiving more information during this interaction. She described,

> Some patients, ...they're not interested. You'll say "Oh your incision's healing up really nice and they'll say, "Oh good." And that's it. So, you know that they're

> not the type of person who really cares if their incision heals up or if you're going to see their scar or anything. Which is fine. There's absolutely nothing wrong with that. But then when you get somebody who is concerned and is curious then there's more information you can give them and so you ... take your cues from them basically.

The nurse took her cues from the patient when providing her with information. She thought taking your cues from the patient happens unconsciously. She described, "You know, ... you're not waiting. When they ... realize that you're commenting on it to begin with ... maybe that triggered something in them.. Maybe I should ask her about what ever. So it just leads where it does."

The nurse related that she doesn't engage in personal conversations with all her patients. She recalled knowing that this patient was interested in conversing on a personal level . She described,

> With her you could tell she was interested in more than just ringing her bell when she needed something because she would talk and she would initiate conversation that was totally unrelated to work. So, you just know that's the indication that they're interested in something other than their incision. And they're interested in you as a person. She was interested in me as a person. And obviously, that's easy to respond to when it's like an open invitation to converse.

She contrasted this with other patients. "There's some patients who, they're not mean about it or rude about it, but you just sense that they would just rather keep it very impersonal." This nurse was aware of and responsive to the patient's interest in conversing and her desire for additional information during this interaction by taking her cues from the patient. When asked how long she spent with this patient during this dressing change, she replied,

> "Well, it took longer than a normal dressing change. . . . It was a simple clean incision. And you could have just whipped in there and do it in 10 minutes. But, I

> know it took longer because I remember standing there and blabbing first. And cleaning up all my stuff and ... just talking to her afterwards. I was probably in there for about 20 minutes on that occasion.

The additional time spent provided extra time for patient teaching and establishing a personal link between nurse and patient that facilitated the exchange of information.

This nurse described another interaction in which she was able to met the patient's specific need for information. She described,

> I remember her being really keen on getting back into things and wanting to do things for herself again and hated just lying in bed trying to recover by lying there. And so she asked for it [the discharge instruction sheet] like even before we even knew she was going home. I mentioned to her ... we have a sheet with all that on it. And she wanted it then. And I said, "Yeah, sure." So I brought it to her and we just basically read over the sheet and she was quite interested in all that.

She recalled that she sat down and discussed the sheet with Connie. She stated, "I did care above and beyond giving [her] this discharge instruction sheet and saying here's what to do, here's what not to do." She described this as being beyond information giving. She explained,

> It was still that ... I would be giving her information but ... it was beyond that. I think we still both had our roles but it was kind of ... a more expanded role. . . . And expanded role in that ... it was more than that. It wasn't her just saying when can I go back to work? Six weeks, okay. How much can I lift? Ten pounds, okay. Should I walk this far or this far, that far. Okay, good, see you later....It wasn't like that.

She recalled knowing this patient's specific information needs, "She definitely wanted information in terms of her recovery. Like, that's what she was most interested in ... is what should I be doing, what shouldn't I be doing. And ... what else she could do toward her recovery." The nurse met this patient's specific needs for information by being aware of the patient's information needs and responding to the patient's request for information when asked.

This nurse also described herself as caring when she reassured this patient. She recalled a time that they chatted in the hallway after she returned from a long walk. She stated,

> She says "Gee, I think I overdid it." Gosh, you know, for someone who's in shape, you'd think I'd be able to walk down to the snack bar and back or whatever. And I think that ... she didn't realize it, but that was her saying "Am I going to always stay this tired? Am I ever going to get all my energy back?" And me being able to reassure her that ... it takes time. I mean it takes a full six weeks before you can even start feeling half normal again. You know, reminding her that "Yeah, you did feel stronger yesterday but that doesn't mean anything's wrong today." And reminding her that even when you go home, you're going to feel 112 percent one day and the next day you're going to feel like you got hit by a truck and that's just because you pushed yourself. You overdid it. But it's going to come and it's going to be slow.

She reassured her by telling her it takes time and that it will come.

Summary.

This patient described this nurse as caring when she made it a bit easier for her to sit in a chair by chatting to her in a bubbly way. She also perceived that the nurse did more than her job. A second interview with the patient was not possible due to the advancement of ovarian cancer. Therefore, it is difficult to know if she would have been able to recall additional information about this or other interactions with the nurse she identified.

This nurse described herself as caring when she conversed in a personal way with the patient. She related that the personal link developed during this interaction led to the patient asking for more information about her recovery. She described being aware of and responding to the cues the patient exhibited that indicated her interest in receiving additional information and in relating in a more personal way. She also described herself as caring when she met the patient's individual need for information by being aware of the patient's need for information and responding to her requests for information. Lastly, she described herself as caring when she reassured the patient by telling her it takes time and it will come slowly.

Dyad #3

Patient Themes

This patient described Linda, the nurse she identified, as caring when she told her what she needed to know a few days after surgery. She related that she was experiencing severe bladder spasms at the time. She described,

> I was having the spasms, but I didn't know they were spasms. I didn't know what was happening and I was bypassing the catheter you know. And I called the nurse in to ask what was happening and ... I said "I think I'm peeing." And she [another nurse] goes "Oh, you can't be peeing, you have a catheter. That's not what's happening." So, she says "I'll see what medication we can get you."

She recalled becoming more frantic when this nurse didn't listen to her concerns or explain what was happening. She stated, "She should have ... cause ... like I got almost frantic cause I didn't know what was happening. I ... just kept peeing over and over and over again." She recalled that about five minutes later, Linda, the nurse she identified came in and explained what was happening. She described,

> I thought well, gee, something, something went wrong and she just explained that it wasn't. It's just the bladder reacting to the surgery and the catheter and it was not unusual.

She recalled that Linda explained this was normal. She stated,

> She explained that what was happening to me was quite normal, quite a normal thing to have happen. I'd asked my doctor how long does it take before your body starts to work properly? And he said "Oh, right away." And so when it didn't,

> that's when I got really concerned and she says ... "You can tell he's never had bladder surgery." (Laughs). She says "No, ... two weeks is the average and anything less or more is unusual." and so she explained that. So, it made me feel much better even though it turned out to be more than two weeks.

She related that Linda also gave her some medication and came back later in her shift to see how she was doing. She recalled that Linda had not been her nurse of the day. She perceived that this nurse had gone out of her way to explain. She stated,

> I thought it had been nice of her to come to the room to talk to me given their busy schedule. I though that was nice of her to come out of her way to come and talk to me and reassure me. . . . Had she been the one that ... had answered my buzzer, well I would have understood that she was trying to clam me down. She came out of her way to come in and calm me down and give me some information.

She described a second time that Linda went out of her way to come and see her during her second admission. She stated,

> When I came back the second time after the week at home with the catheter, she came from the other unit ... to ask how I was feeling and how things were going. So, ... I felt she cared because ..., you know, she took the trouble to come over and see me and how I was doing because I think that they were all kind of feeling bad that things hadn't gone well for me and ... she had more or less assured me that things would go well.

She related that the time she was experiencing bladder spasms was the first situation she thought of when approached about the study and recalled that Linda provided her with what she needed most at the time. She described,

> I think it's probably the time that I was the most emotional, may be frantic and she [first nurse] should have calmed [me] down because I felt like I had no information of what was going on. She [caring nurse] gave it to me and that's what I needed to know. At least, I didn't have to feel so worried. . . . I thought everything was

> supposed to go perfect. That's what my doctor had said. And so when they didn't and nobody said anything except to say that they were going to get some medication, I wanted to know why. She [caring nurse] came and told me why. And then I didn't have to ask. She just showed up in my room and told me.

The nurse's explanation seemed to facilitate a change in her expectations about normal progress after this type of surgery. She described this interaction was one of two caring experiences she had with a nurse that made her hospitalization "bearable." She described what she meant, "It was the fact that ... hav[ing] to spend one more day in the hospital didn't make me cry or get hysterical. Well, okay, I just thought you know, I'll have somebody here who can help me out if ... something starts to go wrong."

She contrasted this experience with an experience she had during the birth of one of her children when no one was explaining what was happening to her. She described,

> It was going pretty badly and I had to go for x-rays and nobody would explain to me why. At this point I didn't realize it, but there was black stuff running down my legs and I know it was from the disinfectant or what ever they use there. And that my water broke. But at that time, I didn't know that and nobody would tell me. [They] just kept telling me to calm down instead of [explaining]. So which is exactly the situation ... with Linda. She came to explain to me why I was having those spasms instead of just telling me "Hey, don't worry about it, we're taking care of it." She stopped and explained it to me so it calmed me down.

She contrasted Linda's explanations with her doctor's. She stated,

> Sometimes the doctor was a bit condescending and [she] was never condescending. . . . She figured I was smart enough to understand things. You know, that I didn't have to be just told it was to be expected my dear. . . . Which was [what] the doctor said. . . . She never talked like that."

She described what she meant by never condescending. "She didn't use terms that she knew I might not understand just to make herself feel, seem important or better educated than me...." She described the nurse as treating her as if she understood and explaining in terms she could understand.

This patient also described Linda as caring when she took time. She stated, "It's just every time she came into [my] room she always took the time to ask how I was doing and try to make me feel better about the situation." She described one occasion when the nurse took time to explain when she was feeling unsure about going home with her catheter. She described,

> He [the doctor] shrugged his shoulders and said it was up to me. . . . [She] explained to me why it might be a good idea for me to come home. . . . Why it might be a good idea and ... what success rate they had with people who went home and came back. And talked to me [and] so, convinced me that it was a good idea to go home for awhile even though it didn't turn out that way. She took the time to explain to me not just suggest it and then leave. . . . She took the time to explain to me why it would be a good idea to go home for awhile. I would relax. Maybe I wouldn't be so obsessed with my bladder. Maybe ... [the tension] was preventing things from working...

She described Linda as caring when she treated her as an individual. She stated, "She wanted to know what it would be like to send me home alone with the catheter. You know if it was a good idea or not. So, it wasn't just to free up a bed. . . . I think they really thought this would be best for me." She described what they talked about on that occasion,

> [She asked] if I was alone. I told her about the kids. You know having a kid at home and so she asked what school he went to. You know, that kind of chit chat. And my daughter not living at home. And then I realized after that they probably ... were trying to do is find out if I'd be home alone with this catheter. Or [if] there would ... be somebody there to sort of watch out for me.

The patient thought the nurse was treating her as an individual when she wanted to know what would be best for her and finding out her individual needs.

She described Linda and several other nurses as caring when they tried to make a catheterization easier. She stated that she had to be recatheterized frequently after her surgery because she had difficulty regaining her ability to void. She related it was very painful and often traumatic to be repeatedly recatheterized. She described a time when several nurses used humor to make it easier. She stated,

> "..They were using a flashlight to try and find the opening. But they decided they would use this big light. And it looked actually like a big Hollywood camera. And (another nurse) said actually they were taking these really sick porno films of me and then one day I would turn the TV on and see myself on it. And she said that while she was putting my catheter in and of course I started laughing and (the nurse) couldn't put the catheter in after that for awhile. That was pretty funny. And that made things easier somehow. . . . I think I didn't concentrate on the pain as much cause I was laughing.

The use of humor seemed to ease the situation and make it less intimidating.

Nurse Themes

This nurse described herself as caring when she tried to work through what was happening with Beth when she was experiencing bladder spasms post-operatively. She described,

> [Beth] was having some really bad bladder spasms and she had no idea what they were. I was in charge at the desk at the time and I went in and tried to work through why she was having the bladder spasms. There's ... a new article out regarding ... the bulbs [if they] aren't filled enough that they can give more problems with the bladder than if they are filled to capacity. So we checked to see if it was full or not and if it had the proper amount in. And as it was, it didn't help but we tried that and just asked her questions as to when she was having the pain

> and how it was bothering her and whether she needed to go on some relaxants to help control the spasms. And basically she just was really uptight and sort of knew what was happening but didn't really have a full comprehension of what was happening as far as her bladder was concerned. When you have bladder surgery, your bladder has to take its time to heal and..she couldn't understand why she...had this pain all the time.

The nurse worked through what was happening by checking and asking questions. She was able to identify the source of Beth's concerns and recalled that they talked things through after that. She stated,

> When she was starting to go a little bit, she'd go into the bathroom and she'd sit there and she'd ... go a tiny bit but it was only a few drops. She felt like she had to go more but she couldn't go more. And she'd have some real urgency and have a bit of bladder spasm. And so she'd pass it without realizing and she figured that ... was the surgery really working as it should work. And I guess we just sat down and talked things through.

She described what she meant by talking things through. She stated,

> I went through what would happen as far as the bladder spasms . . . . You start off going just a small amount and this type of thing. And that gradually it gets better but sometimes it takes awhile and ..you have to just go one day (at) a time. Sometimes they start to go and they figure okay this is a start. You know, ... in two days, I'm ready to go home. But it doesn't usually work that way.

The nurse recognized that the patient required information about what was happening and that she probably had some unrealistic expectations of normal progress after surgery . She described further,

> I basically told her that ... she was more the norm in that case than the abnormal. And that you know a lot of people aren't told that they're going to be in for the length of time they are and they aren't told that they're going to have difficulty

> [voiding] and everything afterwards. And that maybe they need to know more about being told that that's a possibility and so they don't worry about oh, I'm not doing the right thing or this type of thing. Cause I had told her she was doing all the right things that she could .. It was just a case of, you know, you're one of the people who your bladder isn't ready to do it's thing yet.

The nurse talked things through by telling her what was happening and what to expect during the recovery period. She also provided Beth with reassurance that she was normal and that it would take time. The nurse also provided Beth with the information that she thought she needed to know.

The nurse described herself as caring when she allowed Beth to express her feelings during this interaction. She recalled knowing that Beth was frustrated with her progress. She described,

> She was ... really trying hard to do what she thought were the right things and she was doing the right things but it wasn't working for her. And so,... we just talked back and forth, the two of us and... she'd break into tears and I'd just tell her that was okay. There's nothing wrong with a few tears to let it get out.

She related that she had developed a wavelength with Beth and that they talked back and forth each day to try to resolve what was happening. She described,

> I forget even what we started talking about and you ... just develop a wavelength where the two of you kibbitz back and forth and then if things go wrong, you can sort of step in if you need to step in.

The nurse had been able to step in when the patient was experiencing bladder spasms.

This nurse described herself as caring when she got to know Beth and talked about her worries. She described,

> ... She's a single mom and that she had children [at] home and she was really worried for awhile about him [the doctor] sending her home on some medications that might be expensive and stuff like that. And she ... was worried about that.

> And then after we sat down and sort of talked about ways she could go as far as if she needed Social Service's help or something like this if he decided to do that.

She related that she found out her main concern when she talked to her and described reassuring her about going home. She stated,

> And her main concern was I really don't want to go home. I want to stay here because of this. I think what I said was we can get help for you in this regard. We don't mind you staying here, but the fact is that you might be more relaxed at home for while. And then you come back in and things might work better. You know, you got to get away from here and enjoy life or at least smell the fresh air.

She described going back to see the patient once they found out whether not she would go home on the medications. She stated,

> As it turned out, he didn't. He ... only sent her home on a couple of medications. And I asked her at that point, you know, did she feel she needed the help and she said no, she could manage with what he sent her home on.

Through talking the nurse was able to find out and respond to the patient's real concerns. She also checked later with the patient to see if her needs had changed once a decision about going home had been made.

This nurse described herself and several other nurses as caring when they made a catheterization easier for the patient. She recalled that catheterizing was very painful for this patient because of the surgery and that it was often difficult to catheterize her. She stated,

> We had about three of us that had to go in and catheterize her ... because one had to stand with a flashlight and one hold the labia apart in order to find her meatus because we didn't want to hurt her poking around looking for it. And because she was quite swollen down there. ...So we sort of joked about it. I mean, there were about two or three of us and ... one of the girls said that we're bringing the big light for the porno films. And I mean,... by that time, she'd been in a long while and

> she got that ... she just laughed along with us. But it wasn't a case that we were going to do that or anything else. But she got so that she knew when the light came that ... they'd be able to find it.

She related that they often use this approach if it is difficult to catheterize a patient. "We'd try first to put one in and [if] the person had a problem and it's uncomfortable ... we've done in not only with her, but with others that we've had a problem in that regard." When asked what the nurses did that was caring she replied, "We thought it ahead of time so we wouldn't you know, give her any more trauma than she needed." The nurses thought ahead and used humor to make this situation less traumatic for the patient.

This nurse related that she treats all her patients the way she treated this patient. She described,

> I treat all my patients that way. . . . I like to sort of get to know people and you know, not just treat their condition., I like to get to know them as much as I can when I'm looking after them. And if you're at the desk, sometimes you ... have an overall view of every patient on the ward but you don't know [them]. And it happened I had looked after her a few days you know on a one to one basis as her own nurse. And so I knew her better in that respect.

Being assigned to look after this patient gave her the opportunity to get to know her better and enabled her to step in to help the patient resolve concerns later in her hospitalization.

Summary.

This patient described the nurse as caring when she told her what she needed to know when she was experiencing bladder spasms. During this interaction, she related that the nurse explained and reassured her about what was happening. She perceived that the nurse had gone out of her way to give her information. She also described the nurse as caring when she treated her as an individual and when she took time to explain and to see how she was doing. Lastly, she described several nurses as caring when they made it easier for her to be recatheterized by using humor.

This nurse described herself as caring when she worked through what was happening with this patient when she was experiencing bladder spasms. She also described herself as caring when she talked through what was happening and when she encouraged her to express her feelings during this interaction. She described herself as caring when she got to know the patient and talked about her concerns. She described finding out and responding to her real concerns while talking. This nurse also described herself and several other nurses as caring when they used humor and thought ahead to reduce trauma during a catheterization. She described having a wavelength with this patient which facilitate her stepping in to help when needed. She related that she likes to get to know all her patients and treated this patient the same as any other patient.

Dyad #4

Patient Themes

The patient described Joan, the nurse she identified, as caring when she just seemed to be there. She stated, "I don't know if there was any particular thing that she did other than ... she always seemed to be there. She always seemed to be around the room." She recalled that Joan was always walking past her room. She described,

> And even if you didn't need her, her face was always passing by or just looking in. . . . . She'd always seem to be walking past. I may have had to call her once or maybe twice. It wasn't like you're wondering well should I call now or should I wait till they come by? You know, sort of thing. And that was important to me, you know, cause I'm one of these people that I don't like to impose on other people. So it was really hard for me to use my buzzer if I had to call the nurse. It was much better to just see her face walk by.

She perceived Joan as always being there. She recalled that the nurse would frequently pop in and check with her when she was walking past. She described,

> Like whether she was coming there to do something or just happened to be walking by. You know, it was always a wave or you know, like she'd pop in and say "Is

> there anything I can get for you? You know, are you okay?" You know, that sort of thing. There was nothing particular. It was ... she just seemed to be there all the time.

She described Joan as always checking and looking ahead to what she might need when she came into the room. She stated,

> When she walked in the room it was "Hi, how you doing?" Is anything wrong? You know, are you okay? You know, and then it was well, we're going to change the dressings. You know, we should change the dressings. So if you want to lay down, you know, we'll get this over with sort of thing and then, ... if you need anything else, we'll get it for you. Are you okay? Is your pain okay? Cause ... it's been five hours. You know, are you sure you're going to be okay for awhile or do you need something?" ...It was always something, always looking a little bit ahead to what somebody might need.

She recalled that the nurse was always checking in even when she was busy. She described,

> She was always just checking in ... whether she was busy with another patient or walking past with an armload or something. She'd just kind of stop and say, "How's things going?" or "Is there anything I can get you?" And if you'd say something, then she'd say, "Well, okay, I'll be back in just a few minutes. I just have to do this." ...So, she'd explain it, you know. It would take a few minutes but she would be there. So, you weren't wondering, well how long should I wait, you know. . . . "Give me a few minutes and I'll be back."

This patient described the nurse's way in all these interactions as genuine. She described,

> She meant it. It wasn't just a question that she was supposed to ask because she happened to come in the room. She really wanted to know if you did need something or if there was something she could do for you because she would go out of her way to do it.

This patient also described Joan as always smiling and bubbly when she was around the room and thought that this helped her to feel less concerned about her worries and brought her mood up. The nurse just seemed to be there, making sure she was okay and making herself available to help if needed.

She described Joan as being there to do things, to answer questions and to give reassurance. When asked, the patient gave the following examples of what she asked the nurse to do when she checked in. She stated,

> I remember my dressings got all disheveled and stuff and messed up. I didn't know how to straighten them out myself. And ugh! You know, you had tubes coming out all over the place. So, you didn't want to touch anything because you didn't want to disturb anything or hurt anything. You didn't want to make it any worse than it already was. It was much better somebody else doing it than you. So things like that.

She recalled that the nurse also got her things like a hot water bottle or a painkiller if she needed it. She related that she had a lot of questions about herself and what was happening and that the nurse would answer these questions when she checked in with her. She stated, "So you're not sure if a lot of the way you're feeling is the way you're supposed to feel. You know. Whether it be the pain you have or a certain pain you have or whether walking like this is normal." She recalled that Joan reassured her when she asked questions. She described,

> She ... like most nurses say, "Well some ... of it is to be expected you know, but if it continues past a certain point or it gets worse or you know, you notice something different about it, then let us know." Just ... reassuring you that ... was part of it but, you know if it ... doesn't feel right and it's prolonged, then you know, you let them know.

She recalled other times that Joan provided her with explanations and reassurances. She stated,

> Well, there were times [that] certain procedures had to be done. So before she'd ... proceed with them, she'd tell you what to expect, you know? That this might hurt or this might heal this way but don't be alarmed because you know, it's not unusual. It's going to be that way, you know. And it'll be over in a minute or two.

She recalled that nurse would also explain what was happening. She stated,

> If something happened and you weren't sure about it or why it happened, she sat there and talked to you and explained why this could be happening, you know. It just reassured your own doubts.

This patient recalled Joan just seemed to be there when needed. "And when you needed her the most, she'd just seem to be there." She described her as picking up when she needed her,

> Maybe it was the look I kind of gave her, but she just seemed to kind of stop and walk in then. Instead of walking past, you know, you'd sort of ... go like this or I don't know. I don't know ... what I did to make her think that it was something I needed. But a movement or a gesture. But, she seemed to pick up on the fact when you needed her and when you were just sort of busy with your own little thoughts.

The patient also described Joan as knowing when she needed her by sensing her mood. She stated, "And she just seemed to have the knack for knowing when you are a little bit off or when you were, you know, in a , you know, in a pretty good frame of mind or you know, if something was bothering you." The patient was unable to relate a specific time the nurse picked up on her mood. She stated,

> Oh, there were lots of times like that. But none in specific because there was nothing specific you know, that really jumps to mind. It's just sort of whenever she was around, it just seemed ... she'd walk by and she'd just sort of have a

> feeling that you might not be feeling up to snuff so she'd come and ask you. You know, and [if there was] something she could do about it, she would definitely try.

She thought that Joan was able to pick up on things with her and do something before they got out of control.

She recalled that she never felt alone because the nurse was always there. She described,

> But, if she was actually in the room or down the hall, if she saw you walk out of your room, she acknowledged that you were there. If she walked past you when you were walking down the hallway, she'd at least smile at you ... even if she was talking to somebody, she'd at least smile and the eye contact. You know, ... you're my patient and ...I'll see you in a bit sort of. . . . You get that look. . . . I don't know if you can call it a look. It just sort of acknowledges that you're not just a part of the wood work or part of the next patient ... that you have to walk in on. That you're actually a human being that's lying there and probably just as scared as the person in the next room.

The nurse acknowledged her as a person not just another patient. She related that Joan seemed to understand what she was going through. She stated,

> I guess she's dealt with a lot of patients you know, in that sort of... situation. So maybe she understood a little bit of ... exactly how much discomfort you could have. How unsure you were of everything that was going on. Whether she'd been through it herself or not, I don't know. But she just made you feel as if she understood that there was a good time and there was a bad time and there were the inbetween times ...

She described Joan as having insight into what was going on with her. She stated,

> That even if she hadn't gone through what you were going through, she had a feeling of how you were feeling . . . Sort of an insight into what was going inside you too.

When asked for an example of a time Joan had insight into what was going on, she replied,

> Just everything that she did just made you feel that way. The way she reacted around you. What she did when she talked to you even if it was just ... "Hi, ... you okay?" Just asking that question. Just the way she, you know, "Hi, are you today?" Just sort of made you feel well, no I'm not. Or yes I am. Whether you were or not, you could tell her that. And not feel like oooh, maybe I shouldn't say anything you know? . . . It wasn't like a regimented question, "Hi, how are you today?" You know, it was "Hi, how you doing? Are you okay today?" It was the way she said it. You knew that she cared the way you felt.

She related that having Joan there, available and seeming to understand helped her to feel more secure about what was happening. She described,

> Your wonder how your family's doing by themselves,... cause you're usually always there. You're just insecure about a lot of things. You're insecure about how your body is feeling and reacting to everything. . . . And..and when you're by yourself, a lot of that crowds into your mind along with the pain, along with the discomfort, along with everything. And there's just nobody to talk to, you know. Not that I would talk to her about it but it just seemed that when she was in the room, she'd get sort of, make your mind kind of stop overcrowding itself. Because she was so light and bubbly and like I said ... whether she was walking by doing something else, it was always you know, are you okay? Is there anything I can get for you? I'll be back in a few minutes. She always kind of told you what was going on. So you weren't so insecure about what was going on in your life too. And that for me, that was important.

When asked how much time the nurse spent with her, she replied,

> Well, she didn't sit with me for an hour or talk with me or anything like that, but whatever time she did give was ... quality time. So , if it was just two minutes,

> that two minutes of quality, two minutes. No more than any other nurse I don't think. She just seemed to be someone that stood out.

The patient perceived that even a small amount of time spent with her helped her to feel more comfortable and secure with what was happening.

She described Joan as caring when she eased into everything. She described what she meant by easing in,

> But I mean, instead of coming and saying well we're going to do this right now, ... she eased you in to. Instead of lay down, we're going to take this out right now. You know, it was "If you're not busy right now, could we ... take this out. Can we do it right now or do you want to wait a little bit." She just sort of eased you into it instead of ... making it like it had to be done now and no questions asked. . . .Like if you didn't feel comfortable about doing it right then, she'd come back for you.

The nurse eased into everything by asking questions and coming back. She compared Joan's way of easing in to being like a visitor. She stated,

> Like a visitor walks in with a smile on his face or her face. And "Hi, how you doing?" They keep the smile there. They don't lose it and ... it's casual. It's not so stiff, not so formal. Like when your doctor walks in, it's ruff! . . . So you're not feeling like you're in a regimented routine here.

This patient felt less at the mercy of others when the nurse eased into everything. She described,

> You're at the mercy of someone else then. . . . When someone is going to give you something to feel better. . . . I may be sick but I'm at everyone else's convenience. When the nurse can get to me is when the nurse can get to me. Not when I may need her right at that moment."

Nurse Themes

This nurse described herself as caring when she spent time chatting with this patient to develop trust and rapport. She stated, "Just general conversation that's part of [it]. Just drawing a person out. . . . Seeking information if they're willing to give it." The nurse recalled the patient had dressing changes every four hours and that she would spend time chatting with her. She recalled that she asked her about her work and family. She described a time they chatted. She stated,

> She has an 18 year old son and a 13 year old daughter. And her daughter came to visit. I guess maybe I complimented her on her daughter as a very nice young girl. . . . Whether they went to school. Like first of all, of course, how old they are. Whether they're a boy or girl. What's their names? What grades. Whether the boy worked. That kind of thing. Just general information.

She related that they spent most of the time talking about other things such as work, family or her personal experiences during dressing changes but that part of the time she explained. She stated,

> Part of it is explaining what you're doing. And also explaining ... what's happening to her. Why she's needing the dressing changes that she's having. What to expect. What the doctors may or may not do according to what's happening.

She gave the following example of a time she explained. She stated,

> She had a JP drain so she had a lot of [drainage] from the site [which] was basically uncontrollable. ...She was covered by another doctor on the weekend and I just explained to her that each doctor handles things differently. And the one ... who had her on the weekend basically would have taken ... the drain out but was leaving it for the next doctor on Monday and ...that she could probably expect that it would come out on the following day kind of thing.

She thought that finding a common ground also helps to develop rapport. She described,

> Well, basically encourage her to talk about herself and if they are interested, if they ask questions, you share yourself as well...sometimes you can find common grounds with people in terms of family, kids, jobs. So, basically it's just a sharing of information. . . . Like being mothers gives you something similar you've gone through together, You know, not together. You know, similar experiences. If you ... have little people or teenagers or whatever. . . . We had daughters that were very close in age. She had an older son that was older than my son but...still a teenage boy. . . . Sometimes we'd talk about what the kids do or that kind of thing.

She recalled that she had to make a point to establish rapport with this patient. She described this patient as being a private person. She explained, "Initially she just didn't say very much. You know, some people will automatically just talk, talk a lot. But with her, it took awhile to say something cause she seemed to have to establish a trust before she'd say anything." She described ,

> Some people have no problem ... talking... Or you know, sharing their lives or sharing their experiences with most anyone. But other people ... take longer to know. And she's one of the people that takes longer to know. . . . I think you could walk in and out of there and do your physical, the physical things if you didn't make a point to establish rapport verbally. . . She wouldn't ask you to do it. Like she wouldn't ... come out of herself unless you made the effort to know her.

She recalled that she usually is able to develop rapport with most of her patients and that is was the exception not to. She described one time she didn't develop rapport. She stated, "There was always a distance. You know, you never seemed to span that kind of invisible little place that you have to span to know someone."

The nurse also described herself as caring when she checked on the patient. She stated, "Checking on her. . . . Making yourself visible as her nurse. What your name is." She recalled that she checked on her frequently even though the patient didn't need much. She described,

> Just popping in every hour ...just to see if she needs anything. To say, "Hi." That's about it....Just to see that all is well. . . . I think if the patients don't see you often enough, they feel that they're forgotten. ...I find lots of times if I have time to make a round, I usually make a round whenever I have time just to check on everyone and that made them feel reassured I think that they aren't forgotten even if they don't need much."

She described that what she did when she checked on her depended on the patient's needs. She stated,

> Well, it was more physical things cause she had greater physical needs. You know, it was actually doing something, you know? The dressing change or whatever, they were at least every four hours or other needs you know. It just really depended. . . . Sometimes, it was just to pop in and talk to her. That was all.

She thought that checking helped to develop trust and rapport and was reassuring to this patient. She commented that it's important to make contact with the patient whenever you go in the room. She stated, "You don't ever just run and look at somebody's IV unless you know they're sound asleep. You know, it they're awake, you make contact even if it's just a word or a smile and back out again and whatever. You know it's part of nursing."

She thought that developing rapport and trust helped her to find out more about the patient. She stated, "You're establishing rapport with the patient, establishing trust with her. You're finding out what her needs are and then meeting [those] needs. . . . You ... find out more about them." She recalled knowing that this patient needed reassurance and related that she didn't push her to talk. She described,

> I think she was worried about her physical self in terms of just getting well, getting well enough. She had no answers from the doctor as to ... what to expect for the future. So I think until sometimes you get those answers ... you may think you may have ideas but ... I don't ever push patients about that until we actually know

> where she has to go, what the possibilities are. And unfortunately, sometimes they even leave the hospital before you get to that point.

She recalled that they didn't talk about her diagnosis during dressing changes and that she left it for her to bring up. She described,

> I know it was probably on her mind but she really didn't talk about her diagnosis or anything like that. We never got into that. Because basically, ... we really didn't have anything from the doctor to discuss. Although, it was probably on her mind. . . You know, when you have a patient, I guess ... who has come in who's diagnosed with a certain type of cancer and they've come in for a radical hysterectomy which she had done, you know that they [have concerns]. Until the doctor has actually discussed with them their pathology report and the plans, I usually ... don't get into it unless ... the patient tells me that they are really worried about the results of their test you know? So basically all I can be is supportive of what's happening right now until we get to that point. Usually, I leave it for them to bring up if they're concerned about it.

The nurse also thought she was caring when she made this patient comfortable. She stated,

> I didn't have to do very much actually. She was basically self care, preferred independence. So basically, all she needed really was her analgesic when she needed it and just to be sure that her bed was comfortable and make sure her dressing was comfortable, dry and that was about it.

She also recalled doing little things to make the patient comfortable. She stated,

> It was just those little things, you know. Simple things. . . . Just like making sure things are within reach and helping her with her bed or whatever. I don't ever think about those things. . . . If [you've] nursed for very long, I don't think you think that you even do those things.

This nurse commented that she didn't perceive the patient as thinking she was caring. She stated,

> She said, to me, she was a very private lady. And I know the other girls have remarked that you know she's kind of hard to get to know. So, that's why it surprised me she thought I was caring because I didn't feel that you know, that she had perceived [me] that way.

Summary.

This patient described the nurse as caring when she just seemed to be there. She described her as always walking past, always checking in, looking ahead, and explaining if busy. She described the nurse as being there to do things, to answer questions and to reassure. She related that the nurse acknowledged her as a person whenever she saw her and seemed to know what she was going through by the way she responded to her. She also described the nurse as caring when she eased into everything. She perceived that the nurse as being genuine and spending quality time with her.

The nurse described herself as caring when she established trust and rapport by spending time chatting, explaining, and finding a common ground. She recalled making a point of establishing rapport with this patient. She described knowing her need for reassurance and not pushing her to discuss her diagnosis by leaving it to her to bring up. She also described herself as caring when she checked on her frequently and when she made her comfortable by doing little things. The nurse didn't perceive the patient as thinking she was caring and described her caring as what she does for all patients.

Dyad #5

Patient Themes

This patient described Carol, the nurse she identified, as caring when she chatted to her while removing her staples. She described,

> She was saying how nice my scar was. . . . I think she started asking me some questions about myself. How many kids I had you know and stuff like that. ...I

> don't think it really mattered what she was saying to me. She was just making me feel comfortable talking to me like she was doing.

The nurse chatting about topics of personal interest helped her to take her mind off what was happening. She recalled that the nurse also explained what she was doing during this interaction.

This patient also described the nurse as caring when she talked to her while restarting her intravenous. She described that time,

> Like my IV came out of my left arm here and I hate IV's. And when it came out, I woke up in the morning, I went oh no! And it was out a good three inches. And I was trying to push it back in because I knew that they were going to have to do another one on the other arm. But I couldn't [get it back in]. It was hurting too much so I had to tell them . So..they said okay, "We'll have to put one on this arm."

She related that Carol also talked to her while restarting her intravenous. She stated, "The whole time she was talking to me and ... she was saying ... they don't seem very fond of ... you. Just putting me at ease while she was doing it. And acknowledging that .. this wasn't an experience I wanted to go through." When asked what she and Carol talked about, she replied,

> She was acknowledging I know it hurts. She was validating that it does hurt... That it would be over soon ... she couldn't get it in here. She said I'm afraid I'm going to have to try over here. And fortunately it went right in here. I don't know if it's as much what she said. She could have been saying higgelty piggelty I think. But just...that she was you know with that soothing tone again. I realize you're there. I realize this isn't a comfortable situation for you and ... just talking through. ... It was just her way, her whole way of doing it.

She related that Carol's touch was gentle when restarting her intravenous and that she continued to be gentle and talk when she was unable to get it started on the first try. She described,

> I felt ... that her talking to me ... in the end ... was a distraction, but I didn't feel that she had used it as such. I felt that was just her. She was talking to me while she was doing it. And it just came naturally for her. . . . And when ... she couldn't get the needle in ... there was no impatience ... or anything. She just continued to talk to me until she got the needle in. (laughs)

She thought the talking helped to relax and not focus on the nurse having difficulty getting the intravenous started the first time. She related that she wasn't upset when Carol didn't get it started on the first try. She stated,

> It didn't bother me that she was having trouble getting this IV in. She didn't just grab my arm and keep prodding me. I was a person. I wasn't just a thing to stick this needle into.

The nurse treated the patient like a person not an object. She recalled having a traumatic experience when she had an intravenous restarted during a previous hospital admission. She described,

> She [the nurse] couldn't find a vein anywhere. . . . She wouldn't listen to me. She kept doing it until I had to get angry and said look, you're not touching me, go find somebody else. . . .So, you know, maybe that's part of my experience with IV's. Like that was not a good experience.

She contrasted the two situations and the two nurses. She stated,

> Like when I compare the two situations like the other girl-she didn't talk to me or anything. She just grabbed my hand. This is what she was doing. She didn't tell me what she was doing. Actually, I think that was the first IV I'd ever had in my life. . . . She just started jabbing and telling me to keep still and it doesn't hurt and you know, and all this kind of thing.

She recalled feeling okay after the intravenous was started, She stated, "She continued to talk to me while she taped it up and I felt okay. It was like oh, well, now I have another IV. Like you know,... I felt fine afterwards. . . . It wasn't a traumatic experience."

She also thought the nurse was caring when she was in tune and listening to her when she was removing her staples. She stated,

> The second time, I was getting every other one out and [Carol] was doing it again. Now this time, some of them hurt. Some of them were put in funny or something. So when she was taking them out, they were hurting. But she was very careful to ... stop and ... give me a couple of minutes and then ... she'd go to another one and you know she was always in tune with what was happening with me. It wasn't just like well we've got to get these out. It doesn't matter how much it hurts you know. It's the unspoken respect and communication that happens, I guess.

The nurse took her time and wasn't rushing through the procedure. She thought Carol was not only in tune with her but was listening during this interaction. She described,

> I mean, all I had to do was go hhhhh! And she'd stop. I mean, because she had done the other ones and I hadn't had any reaction at all cause none of them had hurt. But she was listening to me. I could tell that because as soon as she heard me wince, she stopped. And she would, you know, she'd stop for a few minutes and she'd either go on to another one or she'd try that one in a different position sort of thing. So she was always aware of my reaction and what was going on with me. Caring enough to listen.

The patient also described the nurse as caring when she did things you take for granted. She described, "Things that you sort of, you know take for granted ... but they're significant in that they were done .... I guess we tend to think of bigger events or more traumatic events or whatever. ...What I mean is just your everyday ... experiences [like I said smiling, and all those experiences] come into one." She called these significant insignificant events. She thought it was just Carol's way to be friendly and outgoing. She stated, "I mean when you walk down the corridor and you pass [Carol], she'll say "Hi, how you feeling today? You know, and that's really nice. . . . I feel that that's just her personality. She's just a friendly person that's outgoing and cares about people in general." She described Carol as picking up her spirits when she laughed with her. She stated, "Like you can joke with her and she'd joke with you. I mean it doesn't hurt to laugh you know. Even though actually I think she said to me one time don't laugh too hard ... Just uplifted by spirits. And when I saw her I found myself smiling." She described this nurse as always smiling and that just having her around picked up her spirits. When asked for an example of a time they joked, she replied,

> I don't know. Like I know if I said something that I thought was humorous, ... when it was expressed to [Carol], she'd laugh along with you, whereas you know something with somebody else it might have just bounced right off ... them, you know.

When asked for an example of a significant insignificant event with this nurse she related the following example. She described

> Waking you up in the morning like coming into the room in the morning and saying "Hi, so how are you feeling this morning" and really meaning it and not just that's what you say to a patient. [Carol] said to me ... "How are you feeling today?" And I said "Much better than I was yesterday. And she said "Oh, ... I'm so glad." You know, she said "Yesterday was just an awful day for you." And not that I wanted to wallow in how awful it had been but here was somebody who had realized how awful it was for me.

The nurse really wanted to know how she was and realized how she was feeling in this interaction. This patient thought that the nurse didn't have to do that. She stated, "She didn't ... have to have that little conversation with me sort of thing. So that's what I mean significant but it wasn't a requirement in the sense of part of her job. But in a sense it is"

She also described this nurse as being sincere when she asked her anything and contrasted her with other nurses. She stated,

> It's almost like they're methodical and they get the job done and it seems to stop there. I mean they ask if you need anything but not with the same sincerity. . . . If you ask for something, if they say, "Yeah, just a minute, I'll get it for you" or even (sigh) "Just a minute I'll get it for you" or "Yes, just a minute, I'll get it for you!" It makes a difference to me anyway.

She also recalled that Carol always called her by name. She described,

> I noticed that [remembering your name] a lot with [Carol] ... [she] would use your name quite often. And that ... personalized it. You weren't just a patient in a bed sort of thing. . . . It shows to me that they put a little bit in. I mean in order to remember people's names, you have to put a certain amount into that. I mean nurses see thousands and thousands of patients. But you know to remember people's names, I mean it would be just as easy not to.

The patient felt like a person not just another patient when the nurse called her by name. She described the nurse as competent like the other nurses but that she put more of herself into everything. She described,

> She knew what she was supposed to do and stuff. But, I think that's what lacking ... a lot of times is that they know what they're supposed to be doing. But that overrides. It closes off the personal part whereas with her, it doesn't. You know, she knows what she's doing but she allows that personal stuff to come out too.

She described receiving a backrub from a nurse who she thought could have put more into the activity. She thought that something was missing when she did the backrub and thought it was the talking and her manner. She described,

> I think she could have put more into it, but it would have ... had to be done a certain way. Like I don't think it was the back rub itself. I think just her mannerism of doing it, I guess. . . . That it could well have been a piece of silver

> that needed polishing. There wasn't much warmth in it. ...The way she pulled up my nightgown and pulled the sheet back was inconsiderate.

The patient described this nurse as being disassociated from what she was doing. She described,

> Now if you've got the backrub and nothing else there, then it becomes ... disassociated. Like she's disassociated from it. It's just a thing. It's just an action. But when you put more of yourself into it, it becomes more.

When asked, she contrasted this nurse with the nurse she identified. She stated,

> [Carol] put more ... in. I mean, I know she was there doing her job but it went beyond that somehow. She put more of herself out there. Whereas this other nurse was more this is my job and there was no personal touches. . . . She considers other people's feelings you know? Whereas, with the back rub, I didn't feel that I was being considered much at all. [I: M-hm. [She] went beyond her job?] Well, I guess ideally no but uh..from my experience, yes, if that makes any sense.

She thought giving the backrub was a chore to the other nurse whereas this nurse seemed to enjoy her job. She described Carol as going beyond what she had experienced with other nurses when she put more of herself into the job.

Nurse Themes

Carol recalled knowing that this patient was anxious about having several procedures done and about what to expect after a hysterectomy. She described,

> She was fairly young. And I think this gave her some concerns too. Although she'd had a lot of discomfort with her medical problem before she had the hysterectomy, she was looking forward to not having that discomfort but she was anxious about the way she was going to feel because she'd had a hysterectomy as well as the immediate physical removal of the drains and removal of the staples.

She described herself as caring when she explained,

> I know that I just sort of gave her a sort of ... overview of what to expect after this. She'd had a hysterectomy and she was fairly young. And she ... had a lot of sort of gray areas about what to expect ... down the road a ways.

She explained what to expect after discharge. Carol also described herself as caring when she provided reassurance to the patient. She stated,

> She didn't have a lot of help when she went home as far as looking after herself. So she needed to be ... reassured that you're quite capable of looking after ... yourself after surgery. Provided you just do the basic necessities like look after yourself and not anybody else.

Carol reassured her about her ability to care for herself after surgery. She described another time she explained and reassured the patient during the discharge teaching. She stated,

> In the discharge teaching, I spent quite a bit of time with her going over what to expect, how she should expect to feel and ... if she's comfortable with herself before surgery, she should be comfortable with herself after. And like probably more comfortable because she wouldn't have the pain. She didn't seem to have a hangup about loss of sexuality or anything with having had the hysterectomy. But she did have some concerns about her sexual activity after surgery. And I imagine because of her age, that this was quite important to her. ...She was ... really quite young. So I just reassured her about her body after. That she would be probably far more comfortable than she had been for a long time. And that she could expect to feel better than she had felt before.

She related that she also reassured the patient when she expressed some "old wives tales" associated with having a hysterectomy. She stated, "In the discharge teaching, I went over all this and reassured her that you don't necessarily gain weight." She recalled reassuring her that her sex life wouldn't be "null and void."

The nurse described herself as caring when she spent time explaining about her drains and staples. She recalled telling her what she could expect before she removed them.

> These [procedures] were very frightening when she was thinking about having them done. So, ... I did spend a fair amount of time just explaining what I was going to do and how other people said that it felt when this procedure was done so that she ... had sort of an idea what to expect.

She recalled telling the patient what to expect when she removed her drain. She stated,

> With [Jill], I .. explained it ... was going to be kind of a weird feeling. It wouldn't be painful. When I finished, I said "how close was I?" And she said "Well it wasn't really weird, but it sure felt awful." But it wasn't really painful. She said "You were pretty close."

She thought explaining what to expect helped to allay her fears. She stated,

> Lots of times, these ladies and [Jill] was one who have ... no idea what's going ... on. So just the fact that you explain ahead of time what you're going to do ... I believe it gives them a better idea of what they're going to have done and it allays some of their fears. If something is going to hurt, I'll tell them it's going to hurt. But I'll try to relate it to some specific pain that they may have experienced.

She recalled that she related her explanation when removing her staples to a specific pain for this patient. She stated,

> Quite a few patients have said it feels like plucking a tender eyebrow. So anybody that ... plucks their eyebrows, they relate to that right away. . . . She said that that was a good way to explain that it wasn't painful but it was a little pick with each one. And some of her staples were rather tight and so they would be as uncomfortable as any would be.

She recalled that she gave this patient ongoing explanations as part of everything she was doing. She described,

> She was right from the beginning afraid of these drains, number one. And also of how they were going to come out, when they were going to come out, was it going to hurt. What did they do in there and why were they in there in the first place. Why didn't they just make an incision and leave that stuff off of there. So you basically have to explain ... why it's there. It's a relief to your system for this drainage tube to be gathering up this material that your body doesn't have to physiologically reabsorb and ... if I remember correctly she just wasn't that comfortable with them or with anything about them really. So ... it was sort of ... an ongoing thing. . . . Even if you're just changing a dressing, you go over a lot of the patient teaching without formally going through patient teaching. I think that is probably quite comforting to the patient .... I have had several people say well you're the first person that's actually sat down and explained this to me ... and that to me, is just part of doing. And I ... feel it's an important part.

She also recalled that she talked to the patient when she removed her staples to distract her. She stated,

> I don't know that there was anything any different than anybody else's but I just chatted with her while I was doing it. . . . I can't specially say what I was talking about. But I probably asked her what did she ... or about her family. . . . And just general interest things probably. I can't remember specifically ... other than I know ... I probably would have ... told her what I was going to do but beyond that, while you're doing it, you just sort of keep ... their attention off of ... the procedure and on to something a little different. . . . I might have talked about what was her appetite like. . . . What the weather was like or it could have been most anything. I couldn't specifically say.

She recalled that when she removed her drain she just told her what to expect and didn't talk. She stated, "It's a little different when you're taking out a drainage tube because that is such a short procedure and I just basically explained ... what I was doing and did it."

She related that she knew the patient was afraid because she had verbalized that. She stated,

> She verbalized that she was afraid of ... any kind of procedure. . . . So, you have to really gain their confidence that you're not going to hurt them and ... I think I did because she seemed very relaxed when I was doing the procedures.

She recalled gaining Jill's confidence by focusing on her. She stated, "Basically, at any time you're looking after, that she is basically the focus at that time. Not that you're just whipping in to do something and out again." She explained,

> Even if you're conversing with somebody else and her, I think that she may feel that you're trying to hurry through this or this is just something that you have to do before you can do something else. I think it's very important that you make them the focus and make them ... feel that they are the center of attention at that point. Because they're the ones having the procedure done and I think they should be the center of attention.

She also thought that it was part of her way not to hurry. She described herself as having "more of a slow delivery" She explained,

> I suppose it's a certain amount of touch, a certain amount of just the fact that you don't appear hurried or in a rush if you can. Or ...lots of times even if you are in a hurry , I like to try and not make it seem like I'm in a hurry right there. If I'm caring for someone, doing something for somebody, the hurrying can be done before or after but not right there.

She recalled that she also told her she would stop anytime she wanted while she was doing the procedures. She described,

> And I would just say if this is uncomfortable for you, let me know and I'll just stop for a minute and then when you're ready, I'll carry on either removing staples or the drains whichever it was-whichever it happened to be at the time. And she seemed to appreciate that. I never had to stop but because she said it wasn't as

> uncomfortable as she thought it would be. . . . When you're removing some of those drains, you never know how far in ... they go so that it's a matter of pulling them out till they come out. If the patient has a say a little cramp or something, you will; if and she says okay stop, that's what you do. You don't just carry on and take it out.

She thought letting the patient know she could stop things gave the patient time and helped relax her. She described,

> If you feel uncomfortable, just let me know and I'll wait for a few minutes. I think she's more likely to be relaxed knowing that you're not going to just whip in there, rip this out, and tear half her stomach out and this kind of stuff. If she knows that you're giving her the time to ... get through this with the ... least discomfort that you can, I think it helps them relax and ... it relieves anxiety if you can do that.

She thought giving the patient time and not hurrying was reassuring and demonstrated caring. She stated, "This I think, is reassuring, for them-for the patient. And I think it demonstrates that you care for them, that you're considerate of them, of their feelings, of their anxieties."

The nurse thought she was caring for this patient the same as she does for all her patients. She stated, "I took care of [Jill] ... on [probably] three separate occasions I think. And I didn't think I was doing anything out of the ordinary to be mentioned for a caring experience." and "I can't specifically think of what I would have done for her that I wouldn't have done for anybody else that would stand out in my mind" And "I did for [Jill] what I do for everybody." She recalled that the explanations she gave this patient were the same as she gives other patients. She stated,

> I still go through the same thing and tell them that ... it is not going to hurt too much blah blah. And if it gets to the point where they want me to stop just to let me know, I will do that with anybody. Even if they don't verbalize that they're afraid.

She thought the experiences she described were the ones that the patient would have thought of as caring. She didn't recall this patient having anything unusual happen or a crisis. She stated, "Vivid in my mind are those other ones ... where there was a crisis, the other ones" She described her experiences with these patients as "indelible." She described, "They'll never be removed. They'll be there for as long as I am, I think. As long as my memory is with me, I'm sure that those will be with me too." When asked she related what was different about these situations. She described,

> ...The more indelible ones are the ones where there seems there was an uncaring situation that sort of allowed it to get to the point where it did. And then to get these people through ... just to reassure them is where the caring part comes in. Just to comfort them and try to work their way through it.

Summary.

The patient described the nurse as caring when she talked to her during procedures by acknowledging, validating, apologizing, using a soothing tone, being gentle and patient. She also described her as caring when she was in tune and listening to her when she removed her staples. She also described the nurse as caring when she called her by name, laughed with her, really meant what she said and acknowledged her feelings. She described many of these interactions as significant insignificant events or things you take for granted. She perceived this nurse to be putting more into her job and went beyond what other nurses did and what she expected from nurses.

The nurse described herself as caring when she explained and reassured this patient about what to expect after a hysterectomy. She also described herself as caring when she provided ongoing explanations about procedures she was anxious about having done. She also described herself as caring when she provided explanations, chatted and focused on her while doing the procedures. She described being aware that the patient was anxious and that she responded to her anxiety by explaining, reassuring, chatting and focusing in several interactions. This nurse described herself as caring for this patient the way she cares for everyone.

Dyad #6

Patient Themes

The patient in this dyad described Barb, the nurse she identified, as caring when she helped her get through her first hospitalization and her first surgery. She stated, "I had never experienced anything like that before. I didn't know what to expect. And I was just like, what happens next? What do I do next?" She recalled feeling very strange and out of place in the hospital. She recalled that Barb was there to show her what to do when she first arrived on the unit. She stated,

> And then I just gave her my forms and she's like "Oh, hi" and ... "We're expecting you" and everything. It's like she knew everything was happening and she's like "Okay, well let's go measure you and weigh you." And she showed me my room. And [my husband] didn't know kind of what to do. He didn't know whether to stay there or to come with me. And she's like "Oh no, come along and then we'll go back down to the room after." And she showed me where everything was.

She recalled another time Barb showed her what to do after she returned from visiting a family member on another unit. She stated, "They were just packing up to go ... so we just stayed for a few minutes and then [Peter, my husband] left. I went back to the nursing unit and I went straight to [Barb], "Okay, what do I do now?" She recalled that Barb had ordered her lunch and told her she might feel better if she ate. She stated,

> She said, "Well, ... how about I order you lunch?" I said, "Well, I'm really too nervous to eat anything I don't think [so]." But when I came back, she goes, "I ordered lunch for you anyway." She goes, "If you want you can try and eat something." She goes, "Maybe it'll calm you down or whatever." So and it did.

She recalled that the nurse had also told her that the anesthetist and other healthcare providers would be seeing her throughout that day.

She related that Barb gave her a pre-operative teaching booklet when she first arrived and that after she read it they went through it together. She stated,

> She gave me booklets on the operation cause I never experienced anything like that before. ... And then she came into the room and went through the booklet with me and explained everything and answered all my questions. Anything that I didn't know she would try and answer or tell me everything she could. She was just very comforting to me.

She recalled that Barb explained things as they went through the booklet together. She stated,

> There was the thing that when I come back home, what type of things not to do, what type of things to do. . . . Or how much you lift and what type of exercises that you can do to help and quicken the healing or whatever. And that was in the booklet and also [Barb] went through it and explained it again.

She related that she wanted to know every detail about having surgery and that Barb explained everything. She stated,

> [Barb] explained what they do ... and what to expect when you come out of surgery. You're going to be really sore and don't expect to jump out of bed. Like she showed me how to get out of bed properly or easier so there's not as much pressure on my tummy. She just went over everything that you can possibly think of I guess!

She recalled that Barb explained everything thoroughly. She stated,

> She goes do you have any questions? I thought I asked everything that I could think of. But then I said to her ... because I haven't been through this type of situation before, I don't know if I'm, asking everything or I'm missing something so she just said well I'll try and tell you everything so you don't have to ..., ask anything. She was very thorough and ... really helpful that way.

She recalled that Barb never forgot to answer her questions. She stated,

> I asked her what time my surgery was ... the next day. She said she'd go find out. And she didn't come back for a long time or anything. Well, not a long time but you know, it seems like forever. (laughs) I knew that she had other people to attend to. But when she came back, she had all the information for me. So she doesn't forget about you, you know. Cause ... when somebody's away for that long, ... you think ... that they forgot. I'm going to have to remind her and then I'm going to feel like a nag. I don't want to have to do that. But she never forgot anything.

The nurse always answered her questions by coming back even if a long time had elapsed. She thought that Barb didn't have to take as much time as she did to help her through. She stated,

> I didn't know what to expect at all and ... it was just like I was going in blind and she ... explained everything to me very thoroughly and she took time out that way by explaining everything. Which she ... didn't have to. She could of just said "Here's the book, read it." When, I read it ... she came back and went over it with me and she just helped me get through that day cause I had so many questions and I just ... wanted to know everything. And she made herself available for me that way and ... I felt that if I didn't have a nurse like [Barb] there and someone who wasn't able to devote that much to me I probably would have felt very uncomfortable. And I might not have slept at all!

She recalled feeling calmer and more prepared after Barb admitted her and explained everything. She stated,

> I remember her showing me everything and familiarizing myself with where everything was and what to expect, who was going to be coming in and seeing me. . . . . Like a lot of information that she had given that it calmed my nerves

This patient also described Barb as caring when she was always there and available if needed. She described,

> I'd go wander around or ... do whatever and she was always there. Like she always came in to make sure I was okay and if I needed anything. And she was just there if I needed. Well, she showed me how to work everything like the nurse's button and ... she said anything that ... I need ... just let her know and she'll be there. And she always popped in just to see if everything was okay. So, she came in and told me what time she was leaving and who was coming on and that she would be there the next day. She was just really helpful that way.

She recalled the nurse probably came into the room 10-15 times from the the time she was admitted at noon until the end of her shift at 1900 hours. She stated,

> I felt that maybe she came into the room on more occasions than she would have because I was so nervous. Just to make sure that I was okay and so I kind of maybe grew dependent on that, knowing that she'll come in to see that I'm okay.

When asked if she used the call bell , she remembered that she didn't need to use it because the nurse came in so often, had shown her where everything was and had explained so thoroughly. She described Barb as having open arms and being available for anything. She explained,

> Anything for anybody not just for myself but for anybody, she would be there to help you. And she'd do anything for. . . . Like ... she just made herself available ... and if there was anything at all that she could do for ... anyone ... she would try her best to do it. If she couldn't do it ... she'd see if somebody else could do it for you.

This patient described Barb as being friendly, personable and her buddy. She described,

> She was just very friendly, open. Like she talked to you about anything. You know, like she tried to strike up a conversation about this and that, about whatever. And so then you're not always constantly thinking or dwelling on what's going to happen or what has happened to you during your time at the hospital.

She described these as light conversations. She stated, "Just light conversations. It wasn't always about doctors or medicine or whatever. But just sort of an everyday type of thing." She recalled that Barb also talked in a personal way. She stated,

> We talked about [her kids] cause her ... children had gone to the same high school that I had gone to. . . . And cause she lives on the southside of the city and ... we talked about that.

She thought that Barb didn't have to take the time to do any of the things she did.

> She assured me that if I needed anything or for whatever reason, that she was available for me. . . . And you know, she didn't have to do that. . . .I don't feel that it was something that she had to do. Maybe she does that with all her patients. She probably [does] cause she's the same person. It was just something that she probably .. didn't have to say. I mean, she could have said that, "Oh, anybody here can help you," sort of thing. She didn't have to say anything at all. She just made herself available for me if I needed anything. And she ... talked to me and just ... helped me to feel more comfortable in the situation and in the place where I was. And at that time, cause I was so nervous, I felt that was pretty comforting or pretty caring at that time. Cause she didn't have to take the time out to do that sort of thing cause I'm sure that she was quite busy. But she seemed to take the time because ... I'm sure she could tell that I was very nervous.

This patient described the nurse as taking more time and doing more than she expected because she thought the nurse probably knew she was nervous.

Nurse Themes

Barb described herself as caring when she listened to Megan during her admission. She related that listening is important with all her patients. She stated,

> That's actually the first step I take in the first communication I have with them is listening cause that's what the nursing admission is all about. And I feel that if they can sense that I am really listening. I'm not just writing down bits of information in

> order to get this form completed, that I am really finding out where they are at, you've already got a caring relationship.

She described the way she listened to Megan during the admission and recalled she does this with all her patients.

> I know I do it with everybody. And it's eye contact first of all. And body language even if I'm in a hurry ..., to give her my total attention while I'm there. I might have 10 other things I need to be doing, but while I'm there, I'm not thinking about those things and I'm thinking only about her. And I think that comes across. And the nursing history helps me a lot and I use it as a tool. And I don't use it ... so much as [a] piece of paper that goes on the chart. I use it as ... information getting but I use it as a tool to let her know that once I've got this information, I'm going to know you better.

This nurse described being focused on the patient while listening, but still being alert for emergencies on the unit or the need to change priorities if other patients required her attention.

Barb described herself as caring when she reassured Megan after hearing she was anxious about being hospitalized and having surgery. She stated,

> [Megan] was anxious because she's been healthy all her life. This was her first experience with a hospital or with being a patient . So, that was the first thing I heard from her. And so that became a factor in the feedback I gave to her. It was reassurance along the way that she was normal. And that it was normal to be anxious. That we would give her as much information as possible so that she would know what lay ahead as it's always the unknown that is the most anxiety producing. And so that was my focus with her.

The nurse was aware that Megan was anxious and she responded to her anxiety by reassuring her. Barb described reassuring Megan by listening, letting her express feelings and dealing with her fears. She stated,

> It was more listening than saying. It's just letting her express. Every time she had a new anxiety or something new, leading her into asking any question she might want to ask about that so that I could..you know, put aside as many fears as she might have. And if some fears were legitimate, I let them be and let her, you know, that is legitimate to be afraid of that. But if there were fears that weren't legitimate like the enema ... just assuring her that it was not a traumatic experience, [not] something she should worry about all afternoon.

Barb related that she believes listening and providing information are helpful to anxious patients. She recalled that Megan didn't express a lot of fears and that she focused on the fears she expressed. She described,

> She didn't express a lot of fears so I didn't make a big deal out of it. I didn't go into detail you know about, ... that anesthetic is risky or anything, just hear her out and if ever I sense there's something where I can calm a fear or help her put it aside, I do. And if I feel it's something that is normal and she can live through the night, I just assure her that we're there to help her. I think that's what I do more. [It's] the things that are hard and that you are worried about, we're here to help you."

She described not brushing Megan's fears off but reassuring her it was okay to be anxious.

> Having surgery, you know, it is something to not treat lightly, you know. I didn't just brush it off. "Oh everybody has surgery and it'll be over and there's nothing to it." I didn't treat it that way at all. Just, you know, There are other people that have surgery, I mean, lots of people have surgery. They come through it fine." So I wasn't feeding her fear. But I was just letting her know that it was okay to feel anxious because it's a surgery.

She also described herself as caring when she listened with not only Megan, but with her family.

> It wasn't just listening with [Megan]. It's listening with [Megan] listening with her husband, listening with her mom. Cause each one of them come to this experience with different background. . . . When I'm with [Megan] realizing what it is that she's telling me and then responding to that. And then with her husband, its something quite different. . . . . In as soon as you hear people out, then ... the more you know about them, the better your response can be to them.

She related a time she listened with Megan and her husband. She stated,

> The next day she was called for surgery at 11:00 and it was booked for 1:30. And he [her husband] was going to come at 11:00. And so when she was called, like then you only had five minutes. And she said "Oh, I don't know it he's going to make it," cause it was about five to 11:00. . . . He didn't get there before she left. And he was going to bring ... nail polish remover. And this was a big thing for her. Like she wanted to do everything right, just like the book said. And we had had nothing to remove the nail polish with the night before. The nurse who'd had her had tried to find something. There was nothing on the unit. And so ... in these five minutes she had left before surgery, I went to [another unit] and we just had a little bit of [not] solvoplast [but] something else. . . . I managed to get ... one nail on each finger without nail polish. That just put her at peace cause now she was ready. Even though her husband wasn't there. Like he was going to bring the nail polish remover. And she just felt ready to go. And then when he came, he was concerned as well. And I said "Well, you know, we found something and we got those two nails clear and everything went really quite well." Then I let him know that she had really wanted to see him and was wishing that he would get there in time, and that if he could wait in the patient lounge ... she would come by there when she came back.

The nurse described herself as caring when she walked this patient through what to expect in relation to hospitalization and surgery. She stated,

> Like it ... wasn't that she was worried about one particular thing. . . . It was just being in this situation. Like this was new. This was happening to her and she just needed to be walked through it kind of.

She described what she meant by walking her through. She stated,

> When we prepare ourselves for a new situation or something that's ahead of us, you know, we mentally prepare ourselves. And she hadn't been able to mentally prepare herself because she hadn't known what to think about. Like it was just something that was coming and it was one big unknown. . . . We have so many tools to do that now like with a pre-op teaching book. and you know, just step by step going through it and letting her know that these are the things that would be happening.

Barb described the information she provided Megan about what to expect and what would be happening during the next day or two. She stated,

> The teaching starts right when they come in. I feel it's important doing the call bell routine. Telling her, you know, her own immediate setting. Making her comfortable where she is right there. And introducing her to her roommate.
>
> And then the pre-op teaching starts by telling her these people are going to be seeing you. . . . It was good that I had told her about all these other things because ... by the time ... I did the nursing history, she had-she had already experience some the things I had told her she would be. And then I gave her the pre-op teaching book and let her read that first. . . . And then I came back in and we'd paged through it together. And then I had her demonstrate getting in and out of bed.

Barb also described herself as caring when she found a link by talking to Megan about something in common. She described,

> She heard me talk to the [patient] who was in the bed beside her about my children graduating from [Lindsey] that was a real link with her cause when I came to her bedside, that was one of our initial things. "Oh, your daughter graduated or my

> son graduated this year. No, that wouldn't have been the year she graduated." When we found out that my daughter graduated the same year that she graduated from [Lindsey]. [We] chatted a bit about [Lindsey] and what the experiences are. . . . And this kind of chatting is taking place while I'm doing her temperature and her blood pressure. And so, I try to incorporate it with the things that I'm doing. It's too time consuming to just sit and chat.

The nurse thought this gave the patient something to identify with and helped her to see the nurse's vulnerability. She described,

> Just gave her something to identify with, you know, in her new situation. And I, you know, I'm a person. I'm a mom. I have a girl that graduated from [Lindsey]. Went through the trauma of a big school and not knowing anybody and hard to fit in and things like that. Cause we just moved here when our daughter was new to [the city] and no friends. So you know, that made her see my vulnerability.

The nurse described knowing how much to share about herself to find a link with patients. She stated,

> I've learned this..as I've gone along, how much of myself to share. Because they're ... preoccupied with themselves. So there's not too much of you that is helpful for them to know. But in almost every situation, I try and find one link and I do this subconsciously. Like now that I'm talking to you, I realize that I do it. ...If you can find one link, something that you can talk about that you both have in common, ... but don't tell them gobs of stuff about yourself in that area. Just tell them a little bit. . . . And then after that, hear them out.

Barb described herself as always caring and that she treats all her patients the same as she did Megan. She stated,

> I feel I treat them [patients] all the same. And if they perceive it as ...caring, it's more the way they respond because I feel like I go out to everyone the same. . . . I feel like my whole experience with [Megan] was caring.

Barb didn't perceive herself as doing any more for Megan than she did for other patients. The caring she demonstrated with Megan was the same was the caring she shows to all her patients.

Summary.

This patient described the nurse as caring when she helped her through her first hospitalization by explaining everything thoroughly, answering questions, not forgetting and showing her what to do. She also thought she was caring when she was always there by making sure she was okay, there if needed and having open arms. She described the nurse as caring when she chatted on a personal level. She thought the nurse did more than she expected by taking extra time to explain, by being available and chatting to her.

The nurse described herself as caring when she listened to Megan and got to know her. She also described herself as caring when she reassured her by listening, letting her express thoughts and feelings and when she dealt with her fears. She described providing her with information by walking her through having surgery. She also thought she was caring when she listened with Megan and her family. Lastly, she thought she was caring when she found a link with Megan that helped her to see her vulnerability. She described her caring as the kind of caring she provides to all her patients.

Dyad #7

Patient Themes

This patient described Barb, the nurse she identified, as caring when she seemed to know what she needed. She recalled an incident in which Barb anticipated her comfort needs during her first post-operative day. She stated,

> I guess because of where my incision was, it sort of made things a little less uncomfortable if you raised the bottom of the bed so that your knees were a little bit elevated. I ... was ... still in the semi-conscious state. I was uncomfortable but boy I'm not sure what would make me feel better. And she just sort of wheeled up the bottom of the bed just a tiny little bit and it sort of took the pressure off the middle a little bit differently than the pressure had been before. And ... I felt much more comfortable. Now I mean that's maybe something very obvious if you cared for a lot of people who've had ... abdominal surgery. It's one thing for it to be obvious. ... It's another thing for the person to just automatically ... anticipate it and do it for you. Maybe I'm not expecting too much or something in the sense that you know, I don't expect people to know all these things or anything.

She thought Barb did more than expected when she automatically anticipated her needs. She recalled she didn't know what would have made her feel better and was amazed when Barb did. She stated,

> I remember lying in the bed thinking that I was uncomfortable and that my abdomen was feeling quite sore. But I wasn't sure if that was just the way it is because of the incision or whether there was something that could be done about it. Cause before I even said that I was uncomfortable she just did this and suddenly I felt, you know, even that fraction ... at that point makes you feel that much better. And I was sort of amazed that it was like she read my mind although she just seemed to know, which is a tall order to require of anybody.

She thought the nurse just seemed to know from experience. She stated,

> I didn't ... ask her or anything but I somehow had the feeling that she either had experienced it herself or that she was just that kind of person that she picked it up from experience.

She described a second time when the nurse seemed to know her need for quiet. She stated,

> She didn't talk a lot in some situations. She would explain, when she needed to, ... if she ... wanted me to get up so that she could change the bed or whatever. But in some ways, she was actually quite quiet and ... like some people are naturally that way and some people are boisterous. But perhaps she was just recognizing that the first couple of days, I ... didn't feel too much like talking cause ... well talking along with everything else takes a certain degree of energy and I didn't feel like I had too much of that so she sort of ... sensed that ... I wasn't terribly talkative.

She described the nurse as caring when she just seemed to know and respond to her needs by automatically making her more comfortable and following her mood. She stated,

> Whether that was having my feet elevated or just not having to make small talk, because you know, in one stage of the process that seems to be what you need and [at] another point .... the day or so after the surgery... I couldn't have made small talk if I had tried so she was very ... quiet and she seemed to ... sort of sense the mood of things and follow along with that. . . . That's what I seemed to need at that point. It seemed to [go] along with my requirements and my way of handling things.

She recalled that she didn't really expect Barb to know what she needed in either situation. She thought it was something that one would hope for in someone who's caring for you but thought it was "bordering on expecting to read people's minds to know what they need. . . . [and] that's an awfully big responsibility to put on other people." She thought it was beyond what she expected from nurses.

She also described Barb as going beyond what she expected from nurses in the way she cared for her. She described,

> She was very competent, the same as all the other nurses. But I really got a feeling that she was concerned about not just ... meeting the requirements of what was the medication that I needed or these were the orders that she had to follow from the doctor. But she was very concerned about how I felt and was I comfortable? And she seemed to sort of go beyond for lack of a better way of putting it. Sort of the way you would expect your family would care for you when you're not well.

She described what she meant by "like family",

> You sort of want to anticipate people's needs if you can or be responsive to them. And sometimes when you're ... the person in bed, you feel like .... doing all the [asking] "Could you do this and get that or this really hurts and could you adjust this?". . . . And it makes it a lot easier to ask when the response that you're getting from the person who's caring is "Of course, sure that's not a problem. I'm quite pleased to help and it's not an inconvenience." . . . There didn't seem to be any resentment or whatever that you were asking again for something or that you needed something because they understood that you were unwell and that you wouldn't be asking if you didn't need any help.

The nurse went beyond what the patient expected from nurses by just seeming to know her needs and caring for her like family.

She also described Barb as caring when she went for her first walk She stated,

> She was the person who let me know that ... I should probably make an effort to get up and go for a walk. When I think back on it now, I think she ... realized that I was pretty unnerved by the idea of having to get up at that point. And ... I think when she realized how ... I was a little bit uncomfortable with the idea, that she ... explained ... I didn't have to go very far even if it was just to reach the chair on the other side of the room or maybe to take a few steps down the hallway and that she

> wouldn't obviously wouldn't send me off on my own. That ... she would walk with me if I needed or if there was a family member around that they would be welcome to do it. But that she would be right around the area and not to be concerned. Because ... I certainly was feeling that ... my bed was sort of a little safe haven. . . . I was worried about my incision. And she ... was very reassuring and you know supportive in the sense that she told me that she would be right there if I needed anything.

Laura thought Barb was aware of how unsure she was feeling and described her as caring when she reassured her by explaining and being right there if needed. She didn't think Barb would push her to walk and felt Barb had confidence in her that she could do it. She described,

> I think if I had said point blank no, I don't want to go through like on the first time I had to take a walk. If I had said no, ... obviously she wouldn't have pushed the point. Not only did I sort of like go on trust that ... she wouldn't be asking me to do this if she didn't think it was a good idea. I got the feeling from her that this was ... her giving me the responsibility that this is going to help you and I know it's going to help you. . . . That's how I read what she was telling me is that she had confidence in me that I would sort of rise to the challenge and try to get up and even if it was ... to the doorway of the room or how ever far I could go.

She related that she was concerned one of her tubes had become disconnected while ambulating. She described Barb's response to her concerns.

> She just ... took my concerns seriously and checked over all the things that I was hooked up to and said, "No, I've checked them and I think everything is fine". . . . And didn't dismiss them but went through the whole process of checking to make sure everything was the way it should be. I guess I felt, that's supportive because it was ... treating me ... not less than an adult because I was a patient in bed but that, you know, under any other circumstances, if I had a legitimate concern,

> people would take it seriously because you're a healthy adult. But sometimes, when you're unwell in hospital, ... your status seems to be diminished from adult to patient and somehow that doesn't carry as much credibility ...

She recalled that at the same time the nurse responded to her concerns by listening and checking them out, Barb also congratulated her for completing the walk. She stated,

> You would have thought that I had run the marathon that ... she was so congratulatory about it. That great walk that I had mad. But really, when I think about it now, I probably took about six steps down the hall and back. so it's sort of funny but at the time, you know, I felt like I deserved ... a ... big applause or whatever for it because it seemed like a monumental task at the time. So that certainly seemed less difficult I guess because ... I felt like I trusted her and like she was saying it was okay to try this.

The patient related that each time she accomplished a task such as walking or eating a certain amount it helped to rebuild her confidence. She stated, "Yes, I did walk around the unit so many times today and you know, I accomplished my job. There's that sense of building your emotional confidence back that ... you're going to get beyond being in the hospital." The nurse added to building her emotional confidence when she had confidence in her and when she congratulated her.

Nurse Themes

Barb described herself as caring when she helped the patient to open up. The morning of the patient's surgery, she recalled sharing about a friend with rheumatoid arthritis. She described,

> [Laura] has rheumatoid arthritis. And I have a friend who has rheumatoid arthritis. Actually it's ... a very good friend of mine's sister. . . . We grew up in the same town and she's had a bad experience throughout and she's handicapped ... to a point that you know she's not living a normal lifestyle. And here's [Laura]. ...you'd never know that she had rheumatoid arthritis. And me sharing that I have

> this friend and that she hasn't had good experience with doctors just opened something up in [Laura] and she told me all about the details about how she's coping with her rheumatoid arthritis and the importance that the doctors play because ... the direction of your care is co-determined by you and your doctor.

Barb related that she tries to find a link, something in common, with all her patients and that establishing this link often leads the patient into talking about their anxieties. She stated,

> Something that you can talk about that you both have in common ... but don't tell them gobs of stuff about yourself in that area. Just tell them a little bit, enough ... to be able to [develop] a trusting relationship. I think that's what it does. And then after that, hear them out. . . . Sometimes that can turn into them sharing quite a bit more. And I often find that with moms and kids, like just share a little bit about you-just so they know you have children, or whatever you find is a link. And then if they have things that they're anxious about ... it will come out.

She thought that Laura appreciated the time she took to listen. She stated, "I think she appreciated that I took time to hear her out before surgery, to really understand her rheumatoid arthritis."

Barb thought that just sharing this little bit about her friend helped Laura to open up and helped her in caring for Laura after surgery. She stated,

> And ... I think me sharing that little bit that I know about how difficult this disease is and how difficult the doctor patient relationship is, just leading her to opening up more about that. That really helped me in my care. I didn't have her pre-op like the night before. I just had her the morning before surgery. . . . She shared enough about that so that after surgery I knew how compromised she was as far as pain went.

She also described herself as caring when she kept Laura comfortable during the post-operative period. She recalled knowing that comfort things would be a priority for her after surgery. She stated,

> I know it's important with all the patients [but] ... especially ... with the rheumatoid arthritis patients. I knew that the comfort things were the most important because taking care of those would avoid extreme distress later. I know if it [the pain] got out of control it would be very stressful."

She knew Laura would be compromised post-operatively because of her condition and used comfort measures to relieve her pain. She described,

> I knew how compromised she was as far as pain went. . . . I didn't wait very long to give her her fist dose. And as soon as four hours were up, I ... woke her to give her second dose. And I think that really stood out in her mind that I cared enough to find out that part of her health history. . . . I gave her a post-op sponge almost immediately after she came back because ... like the longer she stayed still, the harder it would be for her to move. The less anesthetic there would be in her system. It would be easier for her if I did it right away. I just did it right away and then ... did all the measure I could to keep control of her pain. And repositioned her and rubbed her back and you know, put the pillow there just [so]. I was always aware that this body has rheumatoid arthritis.

She described herself as caring when she made Laura comfortable by using comfort measures to control her pain and being aware of her condition when providing care. She thought that Laura was probably aware of this. She stated, "Then after surgery I think she was aware that I was being very careful with positioning and making her comfortable not just, you know, giving the analgesic. It went beyond that, you know."

Barb also thought she was caring when she reassured her during the initial post operative period. She stated,

> She kept apologizing for being a burden or being too vocal about her pain and I just kept saying, "Shhh, I don't want to hear that." Cause I don't feel she was overreacting at all but she has been in control of her pain for so long and now she was dependent on someone else. And I think she felt that every time she expressed that it was painful that maybe she shouldn't be but she was moaning and then in the end, she said "Oh, I'm sorry!" Something about, "I apologize." And she's not that kind of person. . . . She didn't feel good that she was moaning with the pain. She felt ...she had been too vocal about her pain and so I think she said it twice. And I just said, "I don't want to hear you say that, you know. Just, shh, don't even talk about that." And... then I kept reassuring her that she had done just fine and that she was doing really well. And she was, like moving in bed the way she was after surgery. And I knew it was painful for her. I didn't want her to apologize for making me aware of her pain. . . . I knew her well enough that I could do it in a joking way like.. "Just hush up." (laughs) "Don't say another word sort of [thing]. . . .And I needed to know when she was in pain. That's the only way I could take care of it.

The nurse described herself as caring when she reassured her by telling her she was doing fine and by joking. She was also aware of and listened for any cues from the client that she might be in pain.

Summary.

This patient described the nurse as caring when she seemed to know and meet her comfort needs and need for quiet. She described the nurse making her more comfortable by positioning and meeting her need for quiet by following her mood. She thought the nurse went beyond what she expected from nurses when she seemed to know her needs and when she cared for her like family. She also described the nurse as caring when she reassured her by explaining and being right there when she took her first walk. She also perceived the nurse as having confidence in her. Lastly, she described the nurse as caring when she listened to her concerns, responded to them and congratulating her.

The nurse described herself as caring when the patient opened up to her after she found a link, shared something about herself and heard the patient out. She also described herself as caring when she made the patient comfortable after surgery using comfort measures. She described listening and being aware of the patient's condition while caring for her post-operatively. Lastly, she described herself as caring when she reassured the patient by telling her she's doing fine and joking with her.

Dyad #8

Patient Themes

This patient described Shannon, the nurse she identified, as caring when she actually listened to her concerns. She recalled a time when she felt no one was listening to her concerns. She stated,

> ... [I was] just dribbling basically. I couldn't go ... from my room on the third floor downstairs to have a cigarette. By the time I got out of those elevators, I had to run to the bathroom. Otherwise, I'd just go. You know, I had no control and like nothing was working the way it should. And I just knew there was something really wrong. You know, and then like my stomach started to feel really terrible and I felt like I was bloated ... my bladder was just really full. But I could not seem to get anybody you know, on the floor to listen ? . . . .And [Shannon] wasn't at all like that .

She recalled that Shannon heard her concerns. She stated,

> Just showing that she actually really cared you know, when you told her something, she did in fact hear exactly what you were saying. I don't know if she understood. But she made me feel like she understood all my concerns.

She described Shannon as being there when she listened and contrasted her with other nurses. She stated,

> Well, lots of times when the nurses come into your room, they're there in body and that's it. I don't know whether it's because they're understaffed of if they actually hate their job that bad and it's coming through. Like I really don't know why a lot of them are like that but so many of them come into your room. They're very short with you [and] if they ask you something, they really don't listen at all. I mean, you could give them a response that's so out of character and they would never notice. You know, they'd probably say well that's good. You know? And she just wasn't like that. She, you know, she actually listened.

She recalled that Shannon seemed in no hurry to go. She stated, "But she just wasn't in a big hurry. She had all the time in the world you know, just to sit there and listen." She described this as being different from other nurses. She stated, "Like most of the other nurses they come in and you know, do what's required of them. And you know, they're rushing off." She described how she knew she was in no hurry to go. She stated,

> She just sat there to start with. I mean she made no gestures or anything that she had to be going. You know, sometimes they will stand up or whatever or they'll make a comment of something. And she didn't. It was like I was the only one in the hospital. There was nobody else at all. . . . Like she just ... was not in a big hurry to go and she wasn't distracted in any way, you know, thinking like "Oh, God, I wish she'd hurry up and quit talking so I can get out of here and things. She wasn't thinking of all the other things she had to do. . . . I'm sure that it's just the kind of person that she is. . . . That's just her. She'll be like that with everybody, you know.

The nurse was sat down and was focused on the patient giving the message she wasn't in a hurry. The patient thought it was unusual for a nurse to spend this much time. She stated,

> She ... sat there and you know, we talked and talked and all the while she was giving me this back rub you know. . . . Like even with the back rub, like that's very unusual to get. I mean, I've never in my life had one for 45 minutes. I don't

> know any other patient that has. But usually, you know, you get about a two minute back rub because they've got to get on to, you know , to their other patients. She sat there and just you know, visited.

She recalled what they discussed everything during this interaction. She stated,

> We talked about nursing and she had explained to me that you know, why she hadn't graduated right then and ... [why] she was late in writing her exams. Just we'd actually discussed almost everything and anything.

She described Shannon as being genuinely interested and inviting conversation. She stated,

> Like she just ... seemed very, you know, genuine. . . . She was in no hurry to leave. She, you know, she was actually interested. And I mean, the reason that you can tell that someone is interested is by the other competition. I mean, if they only ask you a question and you answer it, it stops there. Or if you ask them something, they give you a very short answer. I mean, it's really hard to have [a] conversation with someone like that.

This patient also described Shannon as caring when she explained. She recalled feeling miserable and frustrated when she was unable to void. She related that even when she was getting bloated, no one would listen to her. At one point, she became so uncomfortable she clamped her catheter. She recalled,

> And my bladder had over 500 cc's of [urine] which you know is a lot of [urine] because I could really damage it ... if I happen to get over full. I just ... thought, "Oh great! Now I have to start from square one again."

She was worried she had damaged her bladder by unclamping and related that Shannon reassured her. She stated,

> I was really unsure about leaving the clamp ... with everything that had happened. And she basically told me like just leave it. You know? And I said yeah, well the doctor said I was supposed to and she basically said well, so what? Like you

> know, you don't feel good. Leave it unclamped. . . . Don't worry ... so much [about] what he says. You know, do .. basically what your body is telling you to do. . . . Like she was the only one that had... basically said that you know, yes everybody isn't the same. Do what ever you have to you know, that's going to work for you.

She recalled that Shannon also explained what was happening was normal after this kind of surgery. She stated,

> When something is not going how you've been told or you think that it should be and somebody just, you know, takes the time to tell you, well that's normal. You know, like don't be upset about it. It just makes a big difference. . . . In how you feel, you know, towards yourself about everything."

She recalled feeling that things weren't so bad after the nurse left and felt more tolerant of the situation. She related she no longer felt like she wanted to take her catheter out and go home. She stated,

> Basically just, you know, try and relax a little bit and it will happen when its meant to and not one minute before your body is healed enough... That's when it will happen and not before no matter how much you try to rush it or what you do. It's not going to happen.

This patient thought Shannon went the extra mile. She described,

> Just the way she was. The time she took. That she actually listened. Like my husband and I were talking about her again this morning and we both agreed that there's very few of the nurses that really seemed to, you know, to go that extra mile. . . . Just, you know, being there, listening and talking. But most of all actually really and truly listening.

She thought Shannon was a great nurse who enjoys her job and has what it takes. She related that Shannon probably treats all her patients this way. She described,

> Like I'm sure that she you know, treats all her patients the same. That she would .. however long it takes to answer questions, do whatever, you know. That , like I don't feel that I got any special treatment from her.

This patient thought the nurse went the extra mile by doing more than she had experienced in her interactions with other nurses. She thought she probably goes the extra mile with all her patients.

Nurse Themes

The nurse thought she was caring when she just chatted with Ellen. She described the time they chatted.

> I do remember that at the end of the shift when the staff were in report, we chatted about budget cuts in the hospital. And she was saying she didn't understand why these cuts would happen in a hospital when these patients need good care. And I was agreeing with her. I said I don't ... understand either.

She recalled that they also chatted about her book and her bladder problems. The nurse described these were things she would talk about to anybody. She stated,

> I mean, I know it was about hospital stuff, but I wasn't thinking of it as a nurse patient interaction like your regular interaction.. It was more of a chatting thing. Like gee,...some things you could talk about with anybody.

She described herself as being friendly and stated, "Like I was just being friendly. Like you know, it was listening and exchanging some comments with her." She recalled that while they were talking the patient did tell her about the problems she was experiencing with her bladder. She described,

> She explained she had this surgery and that she's come back and she has these infections. But, ... she knew how to deal with her catheter, her clamping and unclamping. She understood what she was doing. It wasn't like she was always asking well what should I do ... [being] really unsure. She'd ask me something and I'd give her an answer and that was it.

She related that the patient had been given conflicting information about her clamping routine from two different nurses and she tried to sort things out. She described,

> Like when we were trying to sort this out, I ... asked her, "Well, what did this one ... say?" Clarifying what this nurse had told her previously. She sort of just would take in the information as I gave it to her cause ... then I'd go ask the charge nurse. Well why did So and So say this to her? She'd say well this is why so I'd go back and I'd say this is what the charge nurse said and it's probably because of this.

She recalled telling her which routine she agreed with for clamping and unclamping. She stated,

> But then in the evening, another nurse came in and said if it's making you uncomfortable, ... unclamp it more often and I agreed with that. I said if you can't ... tolerate it, you know, why should you make yourself uncomfortable?

She also recalled reassuring her that the other nurses would know what they were doing. The patient had expressed concerns because she thought that the nurses hadn't checked her catheter on nights. She described,

> I said she's here for the catheter and that they will check it. Because they know what they're doing, you know? I said some of these nurses ... have been here far longer than I have. And I said if they tell you something, they must have a reason. I'm sure that they know what they're talking about . But then I'll give my side and say ... this is what I've been told to do.

She related that whatever she told her she would check with another nurse. She stated, "I always resort to asking another nurse with more experience to make sure I'm not giving her false information." She explained that being a new nurse she's not always sure what usually happens in similar kinds of situations with patients. She recalled trying to give this patient all the information she could. She described herself as always caring but didn't think that this situation involved any emotional caring. She stated,

> Not emotional wise. I mean, it was me. I was trying to give her an answer. I wasn't sure which answer ... I was supposed to give her though. So I thought ... , "Let's sort this out. Let's see why everyone was telling you what they were."

She described this as a time she was "just making sure everything is fine ."

The nurse thought she was caring for this patient the way she cares for all her patients. She stated, "Just almost as part of my routine ... I want them to know that I'm there for them. But then there's other times where I go out of my way to even make it more so because I might sense that need." She described,

> Like everyone gets my best care as much as I [can]. So that was probably just what I would do for any patient on any given day. Whereas there's other patients that I know they need more. More of my time. More of my support. And I spend that extra time with them as part of their [care]

The nurse recalled that this patient did not require anything extra or any emotional caring. She described,

> She wasn't showing that she had this need to talk or this or that she was being neglected in any way like throughout her stay. She was like very confident. She seemed very, you know very sure of herself you know. ...When I came in the room, I did what I had to do. And it was like she didn't need me there. Not that she was pushing me away but I could tell that she was okay with what was going on. She didn't need me to explain things or you know, answer any questions or really so when I chatted with her, it was just chatting. I didn't go away thinking oh I'm really glad I did that. I made a difference. Because I thought you know, she's fine. There's no problem she seems to be having. I mean other than her physical bladder problem. But I mean problems- like emotional problems resulting in that kind of thing.

Summary

This patient described the nurse as caring when she actually listened to her concerns. She described the nurse as being there to listen, taking time to discuss everything and give her a backrub during an interaction. She perceived that the nurse went the extra mile in this interaction and thought she probably cared for all her patients is such a way.

The nurse described herself as caring when she chatted with the patient. She described spending time sorting out her catheter problem and described this as a time that she was making sure everything was fine. She perceived herself as providing routine caring not emotional caring. She described her caring with the patient as the kind of caring she gives on a routine basis to all her patients.

Table 3

Summary of Themes Within Each Dyad

Dyad No.	Patient	Nurse
1	Right there all the time,	Tending to her needs
	to do, to tell, when needed,	Making comfortable
	to make sure she's ok,	Checking frequently
	to talk/joke, to do her job.	Explaining if busy
		Coming back
	Does things carefully	Talking about concerns
		Put at ease by being friendly
	Real caring loving person	Usual care for all patients
2	Bubbly presence	Develops a personal link
	Chatting away	by personal conversing
	Joking	Taking cues from patient
	Enjoys job	Meeting need for info by
		being aware of need
		responding to requests
		discusses info
		Reassuring
		it takes time/it will come

3	Tells what I need to know Explains/Reassures by telling what is happening telling it was normal telling not complications Didn't have to ask Going out of her way Not condescending by treating like I understand using terms I understand Came back to see me Took time to ask/explain Not just a patient but a person Uses humor	Working thru by checking asking questions Talking thru by telling her what's happening that's she's normal Telling her what I thought she needed to know Developing a wavelength Talking about worries Letting her express by telling her it's ok Reducing trauma by thinking ahead Joking Treats everybody that way

4	Just seems to be there by walking past popping in explaining/coming back always checking There to do things, answer questions, reassure Explains/Reassures by telling what to expect/why telling what is usual There when needed by reading gestures sensing mood Knew what I was going thru Easing into everything Always smiling/bubbly Really means what she says Acknowledges me Quality time Has something extra	Establishes rapport/trust by spending time chatting finding common ground making a point Checking by popping in hourly seeing all is well taking care of needs Explaining as part of doing by telling what to expect telling what was happening Knowing need for reassurance Not pushing by letting patient bring up topics Making comfortable by doing simple things Does for everybody

5	Helping through the process	Explaining what to expect
	Chats while doing	Anticipates
	Talking thru by	Knows important info to tell
	acknowledging	Telling what she's lived/read
	validating	Explains ongoing
	apologizing	Explains as part of doing
	using soothing tone	Focuses on patient by
	explaining while doing	not hurrying
	Being gentle/patient	giving time
	Being in tune	Distracts by
	Listening	talking while doing
	Asks with sincerity	Reassures by
	Laughs with	telling things will be better
	Personalizes by	dispelling old wives tales
	calling by name	telling she will be ok
	Acknowledges her/feelings	Does for everybody
	Has something special	
	Goes beyond by	
	putting more in	

6	Helps me get through Explains everything Explains what to expect, explains again, explains thoroughly Answering questions Showing what to do Always there by popping in/checking Makes sure I'm okay Told what I wanted to know Available if needed Available with open arms Doesn't forget by coming back Personal chatting Taking time Friendly/outgoing/liked her Does for everybody Did extra	Reassuring by letting her express dealing with fears telling her here to help telling she's normal giving info not brushing fears aside Walking her thru by telling her what to expect telling what will happen Listening by focusing responding Finds a link by sharing self Does for everybody

7	Just seems to know needs anticipating needs sensing mood Meets comfort needs by positioning Meets need for quiet by explaining when needed not talking much Going beyond by caring like family seeming to know needs Reassured by being right there Listening by not dismissing concerns Takes concerns seriously Realizes feelings Has confidence in Congratulates me	Opens up by finding a link sharing a bit hearing her out Knows what's important Making her comfortable by not waiting to give positioning listening being aware Reassuring her by telling her she's doing fine joking

8	Actually listened by hearing me Being there to listen Not hurrying to go Told me everybody's different I'm normal Discussed everything by inviting conversation taking time Touch Happy/smiling Doesn't go by the book Got what it takes Goes extra mile Treats everybody that way	Just chatting Sorting it out by clarifying answering questions checking with others telling what I think giving all info I can Not giving emotional caring Does for everybody

Part III Effects of Caring Interactions

Patients and nurses were also asked about the effects of caring interactions they described during the course of the interviews. In this section, the third research question is addressed, "What are the effects of a caring interaction for patients and nurses?" Patients' perceptions of the effects of the interactions they described will be followed by a description of the nurses' perceptions.

Patient Perceptions

When asked about the effects of the caring interactions they described, all the patients responded in an extremely positive manner. Many described feeling good or better after these interactions. Several related that they liked the nurse and felt good about the care she was providing. Patient's specific responses have been divided into three categories: (1) felt calmer or less anxious, (2) helped healing and (3) had more confidence and trust in the nurse.

Calmer/Less Anxious

Several patients recalled feeling relieved after the interactions they described. When the nurse was able to anticipate one patient's comfort needs, she described how she felt.

> Well on the very basic level, quite relieved because I wasn't sure myself what I needed and she seemed to figure it out for me. But at the same time a lot of thanks that she knew what to do when I didn't.

One patient recalled a sense of relief when the nurse explained what was happening to her when she was experiencing bladder spasms. Another patient described feeling relieved when she knew the nurse was there and available to answer her questions. Some patients recalled feeling less inclined to complain or use their call bell when they knew the nurse was there and available to help them.

Several patients recalled feeling less worried as a result of the interactions they described. One patient described feeling less worried when the nurse was there. She described,

> You get a little better frame of mind to look at things, you know, and think about things or just say "I'm going to forget it for an hour." Or "I'll think about it when I come back from my walk" or "I'm going to have a sleep and I'll think about it when I wake up" . She just ... gave you that ease that you weren't sitting there like this all the time ... chewing nails you know! Worrying about yourself, your own body. And worrying about everything else that was going on the outside too.

Another patient described that when the nurse joked while catheterizing her it helped her to feel less concerned. She described,

> Sort of ... helps ease the situation and also puts you in perspective when you start laughing at your concerns a little bit. I think they weren't life threatening or anything but they're pretty important to me.

One patient described feeling less worried knowing the nurse was there. She related that the nurse told her she would be there the next day after surgery. She described,

> She told me she was going to be there. . . . I remember coming out of recovery and the guy, H---, ... brought me back to my room. I remember Barb being there and I go, "Hi, Barb!" (laughs) It was like you're going to be there so I just felt really comfortable with her cause she was my buddy ... and I knew she was going to be there even though I [might not] really remember seeing her. But ... I knew she was looking after me so I didn't have to worry about anything. . . . It was like "Hey, you said you'd be there and you are."

Several patients described feeling more relaxed during or after the interactions they perceived to be caring. One patient recalled that the nurse talking to her while starting her intravenous relaxed her. She described,

> Other times I had people do it and ... they're [just] doing it, they don't say one word to you the whole time they're doing it. So, talking relaxes you and you know, helps you through the process I think. And that's what [Carol] did.

This patient recalled that when the nurse kept talking to her when she was unable to start the intravenous the first time it kept her from getting less anxious. She stated,

> If she hadn't been talking to me, I probably would have been watching what she was doing and focusing on her not being able to get the needle in and I would have been getting more and more anxious. By her talking to me ... it relaxed me.

One patient thought it helped to put the catheter in when the nurse made her laugh. She described,

> It may help to put the catheter in easier. I don't know if I was tensing up. I don't know exactly if that makes any difference though they would tell me to relax. I guess it does make a difference though ... how in the hell are you supposed to relax? (Laughs) So making me laugh is one way.

Several patients recalled feeling calmer or more relaxed when the nurse provided them with information or explanations. One patient recalled how she felt when the nurse told her what to expect. She stated,

> You always have that doubt that something isn't right. If somebody can sit there and actually explain to you that this is part of the procedure and this is probably why you feel that way or could be a part of why you're feeling that way, you just feel better. You feel more comfortable with what's going on at that time.

Another patient recalled feeling less frightened after the nurse explained to her what was happening when she was experiencing bladder spasms. She also recalled feeling less worried because she knew things would get back to normal eventually it was just going to take longer than she thought. Another patient recalled that before the nurse came in and spent time listening and talking to her she wanted to "take that catheter out and just leave." She described how she felt after the nurse left. She stated,

> Like, I could handle it for a little while longer ... just the situation, lay back and relax and don't worry so much about it cause you know, maybe if I quit worrying, things would actually happen on their own. I really didn't have any control over

> what was going to happen. Like me getting upset, ... it wasn't going to change the fact that you just have to wait.

Another patient described feeling less anxious after the nurse explained everything prior to her surgery. She described,

> And then after [Barb] coming in and taking care of me and explaining everything and comforting me that way, ... I can breathe again. It was ... okay, everything's going to be okay cause I was really apprehensive. I thought okay, I'm going to get this anesthetic. What if I don't wake up, you know? And then what's going to happen, but after ... I just felt ... I can relax. Everything's going to be okay.

These patients also described feeling more prepared when the nurse provided them with information. One patient recalled feeling ready for the next time she experienced bladder spasms. She stated,

> I was less frightened. Yeah, I was less frightened and well, more prepared I guess for the next time that it happened. I knew very well what it was. I didn't have to get frantic or anything. I knew well geez, I'm having spasms, my bladder's too full. I need to have it drained cause then it was happening every couple of hours.

Several patients stated that they felt more relaxed and able to sleep after their interactions with the nurses. One patient described,

> I was completely relaxed by the time she left, you know. I was ready to go to sleep, you know. I certainly wasn't tense or worried about anything. I was actually looking forward to ... going to sleep.

Patients generally described feeling calmer and more relaxed after the interactions they described. Many patients related that negative emotions they were experiencing such as anxiety, concern or worry seemed to ease. Some felt more tolerant and/or able to cope with events. It seemed that the interactions they described helped them to regain a positive perspective on their situation and what was happening.

Helps Healing

Several patients thought that their experiences with the nurses they identified helped them to heal. One patient thought having someone around who was genuinely interested helped healing. She stated, "I think that to have somebody care and understand helps you get better a lot quicker." Another patient who perceived the nurse was caring when she was right there after surgery thought she was ready for discharge earlier than expected. She stated,

> I think maybe her caring and trying to help me out and telling me what to do and all that. I think that she's the one that really helped me. Because that's fast. Just Friday, I had the surgery and ... I'm ready to go today.

Several patients thought when the nurse was there and picked up your spirits it helped healing. One patient described,

> It can be very easy to become depressed and feeling..lonely ... concentrating on your pain or ... feeling awful with the nausea or whatever. Or being away from your family and missing them a lot . Having somebody around you that is smiley and ... you can have a conversation with and doesn't just split in and out of your room. And makes you laugh..you know, makes sure that you have what you need and stuff. It makes a big difference.

One patient thought when the nurse just seemed to be there it allowed her to concentrate on getting well. She stated,

> A lot of what happens around you makes a difference in how fast you regain whatever you're trying to regain .. a healthier outlook or whatever. Having someone around that gives you that kind of secure, safe feeling, you have more time to concentrate on recovering than you do on how you're feeling.

Several patients described feeling more energetic when the nurse was around. One patient thought she drew on the nurse's energy. She stated, "So having [Joan] around, she just sort of had that extra energy that you seem to draw on it and it gave you that extra energy." Another patient recalled that the nurse's energy transferred to her. She described,

> For example, when I was sitting in the chair and she was making my bed and talking away and just general conversation but in a bubbly sort of manner, it was agonizing sitting in the chair because you haven't been up out of bed and you're utilizing all your energy just to sit there for those few minutes while she makes your bed. So it made it a little bit easier. But if a nurse that just came in and made the bed and didn't really converse with you and didn't pass on some of that little bit of vitality and energy, it made sitting in that chair a long time. An agonizing long time. It just made time ... just go quicker."

Confidence/Trust in the Nurse

When asked about the effects of the interactions they perceived to be caring, several patients described feeling more comfortable with the nurse and expressed confidence and trust in her and the care she was providing. Several patients described liking the nurse and several related that they enjoyed having her around. One patient, who had been experiencing surgical complications hoped that the nurse she identified would be there to care for her if she had to be admitted a second time. She described,

> I was just hoping that she would be because ... you knew that if you did want something or need something ... she would be the one that would get it. And if you did actually have this concern, she would listen to it. I'm sure that all my concerns weren't valid you know, cause when I look back now, probably they all weren't. But she would have at least listened to them. And I actually had no doubt in my mind that she would have told me ... if I was blowing something out of proportion. . . . If she felt something, I think she would tell you.

Several patients described feeling more secure or safe when the nurse they identified was there and looking after them. One patient described feeling more secure when the nurse was there and available if needed. She stated,

> There's a lot that goes on and having somebody there that made you secure makes a big difference. [Joan] was one of those people that made you feel secure, you know. Even if your life isn't so secure, you know when you're in the hospital you need that feeling that at least there you're secure. And if you need [to] cry, you can cry and nobody would say too much about it.

One patient related that she felt more secure knowing the nurse was available.

> She made me feel secure cause I knew that she was there if I needed anything. And cause I didn't know where else to go. Like if I need anything and I had to ask somebody, I would know. Cause I didn't know who everybody was and what everybody did ... and [Barb] made herself very available for me. "I'm here and just come and get me if you need me or just push the button and I'll be there", kind of thing.

Another patient related feeling more secure when the nurse knew and anticipated her needs for comfort. She described,

> It's almost like you feel a little bit more secure because a person is sort of nurturing you in a way. I suppose in a lot of ways at that point you need some nurturing because ... [going into hospital] there's a certain degree of discomfort obviously but there's also fear and concern and what not. And it's a real supportive thing... if the nurse that's caring for you ... is very comforting or supportive of you ... you don't feel so unnerved about the whole thing.

Several patients described feeling more like a person when they had experienced a caring interaction with the nurse. One patient described,

> That you weren't just another patient. You were ...somebody she was looking after and she was going to ... look after you. She made you feel that way. That it wasn't just a job. It was something more. . . .It wasn't just, you know, I'm here to collect my pay check sort of thing. . . . Whether you're going to be here for a day

> or 10 days or two weeks ... you're going to be a part of what I'm doing here every day and I'm going to make sure that you're okay.

Another patient recalled she felt important when the nurse cared for her like family. She stated, "She was treating me like family, the most important person that she had to deal with. And that you know your comforting and requirements were important." A third patient recalled that it made her feel more like a person when the nurse was interested in her home situation. She described, "I wasn't just a patient. Just another patient that we'll try and get out of the hospital as fast as possible. . . . I felt like they cared about me as a person and how I was feeling emotionally and physically."

Some patients felt especially comfortable with the nurse. One patient described, "I felt very comfortable telling her. I could tell her anything. Like if anything happened." This patient recalled feeling uncomfortable and anxious when the intern was in the room and that she discussed this with the nurse. Several patients recalled not being afraid to ask questions of the nurse. One patient described,

> So for me, it was important to have somebody sort of there, just there. If I needed somebody to talk to, I know I could have talked to her. She just made you feel that way. . . . I could have asked her anything, I think. And whether she would have had an answer for me or not, just knowing that was a big relief. And not being afraid to ask her. She gave me that feeling, ... don't be afraid to ask if you're unsure.

One patient described feeling closer to the nurse. She related that the nurse she identified was someone who went on her special list of people along with her brothers and sisters. She related that she still felt close to this nurse when she reread the first interview. She stated,

> When I reread it, the same feeling was there that she was just kind of a special person. . . . Sort of like when you think of a close friend or maybe even a sister.

> Some[one] you're sort of close with. . . . She can't be my sister but ... a friend that's been there when you've needed them.

Several patients described trusting the nurse more. One patient related that she had faith in the nurse that she would get her intravenous started on the second try and contrasted her with another nurse who didn't talk or acknowledge her while she was starting her intravenous. She stated,

> I felt somewhat apprehensive but ... I had enough faith in her that she was going to get it. Like it was nothing like the experience where this other girl was poking me all over the place. That whole experience was apprehensive. I never at any point felt like I was in good hands, you know? I [had] not trust in this other girl at all. Whereas, with [Carol] I did.

Another patient recalled trusting the nurse that it was a good idea to ambulate because of how the nurse had cared for her previously.

> I felt like I trusted her and like she was saying it was okay to try this. . . . I think you sort of..get a feeling that the person really cares for you, how you're doing. So if she's saying that this would be a good thing to do ...you'll be okay if you do this. . . . it made it easier to try. Because I thought well, she wouldn't ask me to do this if it wasn't a good idea. And I really don't want to, but okay, if you think I should, then I will. . . . If I didn't trust that person, I would be a lot more questioning of like well why do I have to get up or go for a walk or are you sure this is the right thing to do. And I.. didn't feel that she was asking me to do anything that she didn't think was okay for me.

A third patient recalled that the nurse she identified was the one she tuned into and trusted. She described,

> I believe [Joan] was just someone that I tuned in to. And that's why for me, she's very special because she seemed to be the one person that I tuned in to. For someone else, it may have been someone else. But, I think if you're ever in a

situation like that, you sort of tune in to ... one or two people. And they just seemed to stick out in your mind [as] very special. The other nurses were also very, very good. . . . [Joan] was the one person that sort of was my pinpoint. . . . If I needed something, I'd call her. Or I'd wait till she got back from her coffee break or lunch break. Not that I didn't like the other nurses, ... I just felt more comfortable with her. So, you sort of pinpoint that person. They become the one person you really trust when you're in there.

Nurses' Perceptions

Nurses perceived the caring interactions they described to be positive experiences for themselves as well as the patients. When asked, most nurses responded that they felt good or fine after the experiences they described. Their specific responses have been categorized into two sections as: (1) development of a caring relationship and (2) feeling rewarded.

Development of a Caring Relationship

Several nurses described having a closer or personal relationship after establishing a link with the patient. Several recalled liking the patient and thought having a more personal relationship made it more comfortable for the patient. One nurse thought it made having gynaecological surgery less intimidating if you had good rapport with the patient. She stated,

> So, I mean, ... in gynaecology [its] more of a person thing right off the bat so it's nice if it's not totally like a stranger interaction with that person. I mean, it's intimidating enough, having ... this gyne surgery or gyne test whatever they're coming in for. Let alone having someone helping you and working with you who's just really cold."

She related that they talked about the patient's incision in a more personal way during an interaction when they established a personal link. She described,

> Like I do remember mentioning it, you know, kind of the usual stuff. You would say "Oh, that's going to heal nicely." Or like I said ... "Oh, you're barely going to even see it." So, we were talking about it but I guess in just ... more of a casual sense. You know, more ... personal.

Another nurse related that it made it easier to ask questions when the patient felt comfortable with her. She described,

> I can go in and ask questions that might be a little, not hurtful but ... sometimes hard questions that they ... feel uncomfortable answering but they don't feel uncomfortable because we've developed a relationship.

Some nurses described taking more of an interest in the patient when they had developed a link. One nurse recalled that she and the patient would chat whenever they saw each other in the halls and that she would often just go in to see the patient when she wasn't busy. She stated, "I would just go in, "Oh, hi, how you doing?" And, ... just talking. Just going in specifically to find out how she's doing." Another nurse recalled that she "kept tabs" on this patient. She described, "[I would] ask how things were going and how she was doing and then she'd come up with questions to me or have a good cry while I was sitting there." She described knowing this patient better and taking more of an interest in her. She stated,

> When ... I'm in charge at the desk, I go around and I see everybody and I go in and check them from day to day. And if you've had anything to do with the patient on a more intimate basis as far as being their own nurse, then I think you just, you know you take a bit more interest than you would other wise. I don't think that anyone else suffers by it but you just know more about what's going on with that particular person.

Several nurses thought having a more personal relationship made it easier for the patient to ask questions once they had established a more personal link. One nurse described,

> It's like when you ask [a] friend and you might even start off by saying this is a really dumb question but, ... then they'll ask you because they know that you're not going to think anything differently of them. And they already know you a little bit on more than just a professional type of relationship because they've talked about some other things. So they know you have some things in common and that you're basically receptive to them. So they're not afraid to ask you.

Several nurses described having a better relationship after establishing a link with the patient. Several nurses related that they knew the patient better after establishing a link with them and were able to provide care in response to the client's needs. They thought it made giving and receiving care more comfortable and relaxed, and helped them to individualize their care because they knew the patient better.

Rewarded

Several nurses recalled feeling satisfied, fulfilled or experiencing a sense of achievement after the interactions they described. They related that they were doing their job and fulfilling their role as a nurse when they were able to meet patient needs. One nurse related that she felt needed when she was able to meet the patient's need for information. She described,

> It was as if the surgical part of her entire medical experience was done and that's what she needed the doctor for. That's what he was there for. And then there was a totally other part of this that she had to deal with. You know, her recovery and her recuperation and her I don't know, sense of self I guess. And that's what she needed someone else for. And that was kind of a role I played.

Another nurse described feeling she had met her goals when she able to help the patient when she was upset and crying. She described,

> [She just needed] ... someone to have a shoulder to lean on occasionally and I didn't mind being the shoulder. . . . It makes me feel good when a person feels that I've been of some help to them. The circumstances don't matter that much. I guess that's why I'm in nursing. I like to be needed. And I felt that she needed me in a certain aspect and I was able to give some help. . . . You sort of have a goal that you've helped a person. And, that maybe you made them feel a little less strange and a little more comfortable in surroundings and stuff. I mean, she didn't really want to be here. She thought after five days she should have been home.

One nurse described she felt more fulfilled after helping an anxious patient to relax.. She described

> Fulfillment I suppose, that I'm doing the job, providing caring and doing my job to the best of my ability anyway. . . . Just to see the patient more relaxed, more confident, more comfortable.

Several nurses expressed that it was nice to be appreciated by the patient for the care that they had provided. One nurse stated it was nice to be thanked by the patient when she made her more comfortable post-operatively. She described,

> "Just a thank you is a reward that you are appreciated. Yeah, and it does make ... it does make you [feel] more appreciated and that you're not doing a thankless job."

Another nurse recalled that it was rewarding to see the patient's anxiety level go down as she provided her with more information prior to surgery. She also related feeling satisfied when she knew her patient with rheumatoid arthritis was comfortable after surgery. She related it was like "something in your pocket too." She described the potential reciprocity of caring as rewarding but not necessary.

> Like the rewarding part is when you see that what you've done . . . . And sometimes it's mutual and they nurture you back which is great. But really I'm the one there. Like it's my role to be the caregiver. And when you realize that the care that you've given has been received and has helped that person, that's the reward.

This nurse related that she knew her patient with rheumatoid arthritis had appreciated her care. She recalled that the patient had thanked her throughout the day for the care she provided. She had been surprised to find out that the other patient who identified her had perceived her in the same way. Several other nurses related that they had not realized that the patient they had been caring of had perceived their caring.

Part IV: Additional Findings

Some additional findings emerged during the data analysis that were not directly related to the three research questions. However, these findings are of interest to report and will be discussed in the following portion of the thesis. The additional findings are reported below.

All Nurses were Caring

Many of the patients who participated in this study related that all the nurses they had contact with were caring. They described all nurses as caring, friendly, cheerful or helpful. One patient stated, "Every nurse that looked after me made a difference in my stay there. They all cared." Another patient stated, "All the nurses were really caring. All of them were very helpful." Several patients related that all the nurses were "really great", "very good" or "excellent nurses." One patient stated,

> Thank God for the nice nurses because ... I got more information from the nurses ... than I did from my doctor. My doctor flitted in and out, didn't seem to want to be asked any questions. If the nurses would have been like that, it would have been awful. . . . I mean, I know doctors have schedules, but I guess I would say my doctor doesn't have a bedside manner but most of the nurses did. It would have been a really awful, scary experience if they had all been like that.

Another patient related that the nurses were "always caring" and always tried to modify the effects of difficult and painful catheterizations. She stated,

> They were always very careful to try ... not to hurt me as much as possible. They would often just touch you. Kind of rub your arm. The kind of thing to make you feel a little better. And apologize lots of times. . . . They knew it was painful for me to have the catheter put back in.

She related that the nurse she identified for the study had been a nurse who had provided her with information when she had needed it most. Another patient related that all the nurses seemed to know what she was going through. She stated,

> Most of the nurses on that floor and [I] don't think there's any that are ... exceptions, all knew ... what you were going through. Whether ... because they've had to deal with it every .. day with so many different people. So, they were all caring.

She related that the nurse she identified to participate in the study had that "little something extra." She stated,

> They were all as equally caring to look after you. But [Joan] just had that little something extra. I don't know what it is. You know, every once in awhile, there's somebody that comes along that has that little something extra. . . . She just seemed to be the one that stood out in my mind, with all the nurses that looked after me which were all exceptional nurses, she just seemed to be the one ... and I missed her when she wasn't there.

She thought it might have been this nurse's genuine interest and sincerity that set her apart from the other nurses. She related that she tuned into the nurse she identified and thought that patients probably tune into one or two people they trust during their hospitalization.

In this study, patients were asked about caring interactions with other nurses. Seven of the eight patients described additional caring interactions with other nurses on the unit. Many of the patients described several additional interactions that involved numerous other nurses. Most of the interactions described with other nurses were similar in nature to the interactions they described with the nurse they identified. One patient ,who had identified a nurse as caring when she explained everything prior to surgery, related having a similar experience with another nurse. She stated,

> [Jan] was there the same days that [Barb] was. . . . She just kind of made sure that I'd know [every]thing. If there was any questions that [Barb] may have missed [she answered them]. She was just a really friendly lady also. Very friendly. And I felt very comfortable with her too.

This patient described all the nurses as caring but recalled developing more of a relationship with the nurse she identified and one other nurse. She stated,

> Every nurse that I had ... during my stay there was very caring, very helpful... like anything that I wanted. I mean they'd be there. I think just because the fist day that I was admitted, there was so much I had ... to ... ask and so many things that I wanted to know, I got more [of a] relationship with [Jan] and [Barb] cause they were the ones there .. to answer my questions and to help me through everything.

Several patients described other nurses as caring when they explained what was happening to them or provided them with reassurance. One patient described another nurse as caring when she explained everything she was doing and talking to her while she removed her staples. Another patient described a nurse as caring when she took time to talk to her. She stated,

> She took time to come and talk to me at night and talk about other things besides what was going on in the hospital to me. She talked about her trip to S---F--- where she had bought this stuff to do needlepoint and she asked about what kind of things I was interested in. Like I think she was trying to get to know me. I really enjoyed her a lot.

Other patients described nurses as caring when they called them by name or asked them how they were doing at intervals during their hospitalization.

Several patients commented that they felt safer or more secure knowing that the nurses were there. One patient stated, "And throughout my stay, there was that security that you could fall back on the nurses. They were going to be there." Another patient stated, "All the rest were very attentive. Constantly ... asking me if there was anything that I needed." One patient described feeling safer knowing she could press her call bell and a nurse would answer. She stated,

> I knew somebody would take care of it. Whatever the problem was, ... one of the nurses took care of whatever the problem was. Even if it was just talking to me

> about it, you know and didn't have to give me drugs, just talk to me about it, it made me feel safe that I was in good hands.

A third patient recalled feeling the unit was a safe environment. She described,

> It was a safe environment. . . . Somehow those people were the ones that ... know me and know what my situations was and so that was a safe space to be in ... because of how they had cared for me. I trusted them so I figured they were the safe place to be.

She described the reasons she identified the particular nurse for inclusion in the study.

> I think when [I] look back on it now, the reason why I identified her was because she was the person that was caring for me like the day after my surgery. . . . You're sort of at ... the more vulnerable end of your ... scale because you're pretty weak and confused and what not. And she just struck me as a very caring person. I don't know if it had been a different nurse on that day if I would have said her because they were all pretty, pretty, pretty good to me. I mean some of the things that they do for you,... the only other person that I can think of that would remotely be interested in doing that is your mom because she's your mom. . . . Like everyone seemed to treat me pretty well.

Many of the patients in this study described all the nurses as caring. Almost all the patients described additional caring interactions involving other nurses. Some of the patients commented feeling more comfortable and secure on the unit because of the care provided by all nurses. Although it was not the purpose of this study to describe noncaring interactions, it should be noted that few examples of noncaring emerged during the course of the interviews. Most patients related having a positive experience during this hospitalization. Some felt that the attempts the nurses made to involve them in their care contributed to a better experience during this hospitalizations than previous hospitalizations. The nurses in this study seemed to provide caring at a critical time in the patient's hospitalization. Since the length of hospitalization for patients in the study was relatively short, it is not surprising that one or two nurses were perceived as caring. Particularly, if one nurse was assigned to care for them during the critical one or two day period when they required additional caring.

V. DISCUSSION

This chapter is divided into four sections. In the first section, the limitations of the study are discussed. Next the findings are discussed in relation to the relevant literature presented earlier. Thirdly, recommendations and implications for nursing education, practice and research are presented in light of the findings. Lastly, a summary and conclusions is given.

Limitations

Design

In this study, a qualitative research design was chosen because it was appropriate for the phenomenon being studied. However, using this type of design does have accompanying limitations. One limitation is the limited generalizability of the findings. In an exploratory/descriptive design like all qualitative designs, findings cannot be generalized to patients or nurses who were not subjects in this study (May, 1986; Sandelowski, 1986; Seaman, 1987; Hunt, 1991). However, the purpose of exploratory/descriptive studies is to gain insight into phenomena rather than to generalize results to other populations (Field & Morse, 1985). Additionally, the findings of a descriptive study should sensitize the reader to the point of view of the participants. "As a sensitizing device, qualitative findings are important in and of themselves, since it is the richness and detail of the data that give the reader an understanding of the subject's social world" (Knafl & Howard, 1986, p. 267). The words of the participants at times are so strong and heart-rending that their comments speak for themselves and have an impact which can be felt by others. It is anticipated that readers of these findings will be sensitized to the perspectives of the participants in this study. Additionally, the nurse and patient who were consulted to validate the findings of this study, indicated that the descriptions of study participants rang true for them.

A second limitation of qualitative designs is the subjective nature of the analysis. It is often difficult to replicate the findings of the researcher or to objectively assess the accuracy of findings. In this study, another nurse was asked to review the transcripts of two dyads and the findings to determine the logical development of the categories by the researcher. As reported earlier, she was able to follow the decision trail of the researcher. Additionally, the members of the researcher's committee reviewed the development of the findings. However, this does not ensure that other researchers would reach the same conclusions as this researcher.

In this study, the main method of data collection was guided interactive interviews which were audiotaped and transcribed. Participants may have felt restricted or reluctant to provide information for several reasons. In the interviews, participants were asked about caring interactions with a specific patient or a specific nurse. Although there was an opportunity for participants to describe caring interactions with other patients or nurses, the main focus was on interactions with a specific individual. Participants may have felt restricted in their ability to talk about other interactions beyond the dyad. Secondly, patient participants may have been reluctant to describe noncaring interactions involving identified individuals. Likewise, nurse participants may have been reluctant to be critical in describing their experiences with patients, particularly since it was made known to all that the other participant in the dyad was going to be interviewed by the researcher. A consistent and conscientious effort was made by the researcher to reassure participants that their point of view was of value and important to share with a nonjudgemental listener. Also, as mentioned earlier the interviewing skills of the researcher were deemed to be satisfactory by an external reviewer in eliciting descriptions that were rich and comprehensive. Participants were also reassured that confidentiality would be maintained and that their personal identity would not be revealed. Although numerous strategies were employed to facilitate participants to share their perceptions and experiences openly and honestly, the possibility does exist that participants may have been constrained or self-conscious in responding.

Sample

In this study a convenience sample composed of volunteer participants was recruited from two gynaecological surgery units. Since nonrandom sampling methods were used, the possibility that researcher bias entered into the selection of the sample does exist. There was also the opportunity for the charge nurse to bias the selection of patient participants. The researcher did consult regularly with the charge nurses on the two units to review the patient census sheet to identify potential participants. On several occasions, one of the charge nurses skipped a name on the list. When this occurred, the researcher asked the charge nurse about that particular patient. In her response it was obvious that patient did not meet the criteria for the study because she had not yet had surgery, was physically unable to be interviewed or could not speak English.

A second limitation in relation to the sample is the number and characteristics of participants. Eight patients and seven nurses were included in the study sample. Since this number is relatively small, it is possible that new data might have been collected if a larger number of participants had been interviewed. Also, all the participants in this study were women. Since men were not included in the sample, there is the possibility that their perceptions of caring interactions may have differed from the perceptions obtained. Additionally, participants were required to speak English and therefore participants not fluent in English were not included. It is possible that other cultural groups may have differing perceptions of a caring interaction.

Setting

In this study, all the participants were recruited from two units within one hospital. The possibility exists that there were factors in the setting that contributed to the participants' perceptions of caring interactions. As identified previously, many of the patient participants described an overall perception that all nurses were caring. There may be particular group dynamics, management strategies or staffing patterns that influenced the perceptions of participants. One might wonder if the level of patient and nurse satisfaction on these units differs significantly from other settings. Therefore, one needs to be aware that the setting may have influenced the data and ultimately the findings.

Relevance of Findings to the Literature

The descriptive categories of a caring interaction which emerged during the data analysis will be discussed in relation to the relevant nursing literature reviewed in Chapter II. Responses of participants in this study are reviewed by comparing and contrasting their responses to those of participants in the nursing literature. Categories describing patient perceptions of a caring interaction precedes a discussion of categories highlighting nurses' perceptions.

Patient Perceptions

Nurses' Way

Patients perceived the nurses' way of being and doing as caring in this study. This category is consistent with the findings of Brown (1986), Miller, Haber and Byrne (1992), Paternoster (1988), Reiman (1986). Paternoster found that the affect of the nurse conveyed through non-verbal affective behaviors such as smiling, being cheerful and happy were important indicators to patients that the nurse cared about them. Reiman reported that when the nurse responded to the patient as a valued individual, patients perceived this as caring. In her study patients perceived they were being treated as a person of value when the nurse was caring. Patients perceived the nurse as not caring when she was rough or belittled them. Brown found that patients perceived nurses to be caring when they recognized the patient's unique qualities and needs. Miller, Haber and Byrne reported exhaustive descriptions of a caring interaction from the patient's perspective and found that "Caring nurses connect with you on a professional level but in a personal way" (p. 143). These authors described caring nurses as greeting patients with a smile and making eye contact. According to these authors caring nurses do these things because they know the patient is a human being apart from their tubes and their condition. The nurses in their study thought that caring was a way of being, an attitude, or a personality that lets patients know that you care.

In several studies of patient and nurse perceptions of important nurse caring behaviors, listening, talking and touching were perceived as the most important caring behaviors by nurses (Larson, 1986, 1987; Mayer, 1986; von Essen & Sjoden, 1991a; Rosenthal, 1992). Forrest (1989) in her study of nurses' experiences of caring reported respect being an important theme in the category of involvement. Respect included acknowledging the patients' presence and recognizing individuality. In studies of nurses' perceptions of caring, Morrison (1991) in a content analysis of nurses' perceptions found that personal qualities of the nurse were perceived to be influential in determining nurses' perceptions of caring. Two of the personal qualities identified as indicators of caring by nurses were, being patient and genuine. The findings of these studies are similar to those of the present study.

Helping Through

The patients in this study described the nurse as caring when she helped them through a new or difficult situation in a variety of ways. Many patients described the nurse as caring when she was in tune with their experience. This finding is consistent with the findings of Swanson (1986, 1988, 1991). Swanson (1991) described 'knowing' as one caring process. In 'knowing' the nurse understands the personal meaning of the experience for the patient. When the nurses in this study were in tune with their patients, patients described the nurses as seeming to know and understand what was happening with them. Swanson also described the category of 'being with' as being related to 'knowing'. In a few instances, such as when the nurse sensed and followed along with the patient's mood, it would seem she not only understood the patient's experience but was feeling with her. In a study of nurses' perceptions of caring, Ford described nurses as being in tune with the world of the patient. She defined being in tune with the patients' world as having "a feeling about what is happening and to know it, it is rooted [sic] in a connectedness at a deeper level" (p. 160). The patients in the present study described the nurses as caring when they were in tune and responding to their experience.

The nurse being available and attentive was also perceived as caring by many patients in this study. There are several studies in the literature that have reported similar findings (Reiman, 1986; Brown, 1986; Paternoster, 1988; Cronin & Harrison, 1988; Keanne et al., 1987, Miller, Haber & Bryne, 1992; Swanson, 1991). Brown reported that in analyzing patients' descriptions of caring incidents when the patient felt cared for by a nurse, the theme of 'reassuring presence' emerged. The patients in Paternoster's study perceived the nurse to be caring when she was dependable and solicitous. Being dependable was defined as "nurses are there when you need them" (p. 19). When nurses were solicitous, "They were in and out all the time, asking if I need anything, how am I feeling, telling me not be afraid to ask" (p.19). In her analysis, Reiman described the 'nurses existential presence' as being important to patient perceptions of caring interactions. Existential presence is defined as the nurse being physically and emotionally present. Reiman also reported that patients did not have to solicit the nurse's presence, rather the nurse knew when the patient needed her. In two studies of nurse caring behaviors, Cronin and Harrison, and Keanne et al., found that nurses were perceived to be caring when they were available and accessible to their patients. In Swanson's description of the caring process of 'being with,' in addition to feeling with the patient, the nurse also conveys an ongoing availability to the patient which is consistent with the emotional availability described by the patients in this study. In the study by Miller, Haber & Byrne patients described nurses as caring when they were "always there to help" and when they let patients know that is was okay to call. In their study, caring nurses " ask what you want and take care of what you want; that's very important, knowing they're always there to be of assistance" (p. 143).

In studies by Ford (1990) and Forrest (1989) the authors reported similar findings that are consistent with the nurse being available and attentive. Ford (1989) described the theme of 'being attentively present' as integral to all caring encounters. "Being attentively present means that the nurse takes time to listen, she gives her undivided attention to the patient and is able to focus on his needs" (p. 160). This is certainly similar to the descriptions of the patients who described the nurse as caring when she actually listened and when she took the patient's concerns seriously. Forrest reported involvement as an important theme in nurses' perceptions of caring. Involvement includes 'being there' and the nurse 'having a physical and emotional presence' that "says to patients 'you're there all day for them'."(p. 819). In this study, the nurses were perceived to be caring when they conveyed their availability to patients by their words and actions.

Patients in this study described nurses as caring when they knew what they needed. This finding is consistent with findings reported in the following two studies. In the study by Miller, Haber and Byrne (1992) their description of patients perception of a caring interaction found that "caring nurses know which of your needs to meet first" (p. 144). They reported that caring nurses know which needs are most important for the patient at a particular time because they are not rote or mechanical in their care. In the study by Paternoster (1988), patients described nurses as caring when they were willing to accept the responsibilities of the caring relationship, which includes anticipating the patient's needs and providing services without being asked. Paternoster also found that patients perceived awareness and attention to comfort needs as an important indicator of care. In the present study, one patient reported the nurse as caring when she met her physical comfort needs.

In Swanson's (1986, 1988, 1991) work she described 'enabling' as one of five caring processes. Enabling means "facilitating the other's passage through life transitions and unfamiliar events" (p. 164). An important aspect of enabling is the provision of information and explanations. In her study of the caring needs of women who miscarried, the process of enabling facilitated these women to grieve and get through their loss. The women perceived caring when the nurse provided them with information which confirmed their grief responses were normal. Several patients in this study perceived nurses to be caring when they provided them with information and reassurance that they were normal when they were experiencing certain phenomena. In Lemmer's (1991) study of parental perceptions of bereavement, parents described nurses as caring when they provided them with information about what was happening and what they could anticipate during the bereavement period. In several studies of nurse caring, providing information was perceived as caring by patients (Brown, 1986; Lemmer, 1991; Swanson Kauffman, 1986, 1988; von Essen & Sjoden, 1991b).

In several studies the most important indicators of nurses' caring according to the following researchers were instrumental behaviors indicative of technical competency and safe physical care (Larson, 1984; 1987; Mayer, 1986; Rosenthal, 1992; von Essen & Sjoden, 1991a). The descriptions of caring interactions described by patients in this study included a broad range of behaviors. Several patients commented that the nurse was as competent as other nurses but what set her apart from the other nurses was the ability to see the patient as a person and respond to individual needs at a particularly critical time. Although patients were not asked to rate importance of behaviors, none expressed direct concerns about the competency of the nurses and, in fact, it seemed to be a given that the nurse was competent. It is possible that once competency is established, other caring behaviors become more important to the patient.

Going Beyond

The theme of going beyond has been reported in one other study. Ford (1990) described the them of going beyond from the perspective of nurses. Nurses in her study described going beyond as becoming "personally involved in the patient's situation. The patient's concerns becom the nurse's concerns and her actions reflect her commitment to the patient" (p. 159). In the present study, patients described going beyond as a time when the nurse did more than they expected or went beyond what they believed to be the requirements of the job. In this sense, the patient's descriptions of going beyond differed from those in Ford's study.

Nurses Perceptions

Establishing a Link

The findings in this category were consistent with the results reported by Forrest (1989) and Larson (1986, 1987). Forrest, in reporting nurses' experiences of caring, described the theme cluster of closeness which included talking with the patient, taking advantage of opportunities during nursing care, valuing the relationship with the patient, acknowledging fit of personalities and in some cases self-disclosure. The theme of closeness was part of the category of involvement. In studies of patient and nurse perceptions of important caring behaviors, Larson found that nurses place a high value on the subscale of "trusting relationship." This subscale includes items such as "gets to know patient."

Miller, Haber and Byrne (1992) developed exhaustive descriptions of nurses' perceptions of caring interactions. They reported that "Caring nurses establish relationships that are always professional but personal" (p. 145). They described these nurses as building rapport by introducing themselves, establishing eye contact and calling patients by name and touching them if appropriate. In the present study, the nurses described developing rapport by conversing, finding a common ground or sharing self.

Kahn and Steeves (1988) explored the meaning of caring from the perspective of nurses. They reported 'liking as the basis for caring' as one of the four major themes which emerged during their analysis. Nurses in their study described fitting, clicking, or meshing with the patient and that 'liking' develops. They reported that a friendship develops if the relationship persists over time. In the present study, the relationships were relatively short term. However, two nurses did relate that they would often stop in and see the patient even when they were not assigned to care for them. Kahn and Steeves reported that for the nurses to describe the relationship as caring, a liking had to eventually develop.

Nurses in the present study described establishing a link as a means of getting to know the patient and some individual nurses mentioned liking the patient, but it was not evident that liking was necessary for them to be caring. It is interesting to note that one nurse described making a point of developing rapport with a patient she perceived as reserved and quiet. Additionally, this nurse did not perceive the patient as receptive or responsive to her caring.

Responding

Responding to the patient's individual needs by picking up expressed cues, listening to the patient's experience and being aware of past experiences are findings consistent with those of Reiman (1986), Forrest (1989), Ford (1990) and Miller, Haber and Byrne (1992). In Reiman's study, one theme of a caring interaction as described by patients was "listening and responding to unique concerns of the individual as a person of value" (p. 101). In Forrest's (1989) analysis of nurses' experiences of caring, the category of 'interacting' emerged. One theme cluster in this category is 'picking up cues'. These nurses described using cues to guide depth and judge the impact of interaction, to tell the nurse how far to go in talking about feelings, and that overt and subtle cues can be missed and need checking out with the patients. Miller, Haber and Byre (1992) in their exhaustive description of nurses' perception of caring describe caring nurses as monitering "their patients by simultaneously assessing, anticipating, prioritizing, and meeting their ever changing needs" (p. 146).

The results reported by Ford (1990) bear some similarity to the findings of the present study. In her descriptions of two themes, sensing the patient's vulnerability and being in tune with the patient's world, the nurse is attentive to the cues. In sensing the patient's vulnerability the nurse responds to the cues of helplessness or loss of control. When the nurse is in tune with the patient's world she is more sensitive to the needs of the patient and picking up on cues is easier if the nurse has had a similar personal experience. It was not evident in this study that personal experience played a role in the nurses' responses to patients. However, aspects of personal experience that might influence professional caring were not explored. In the present study, the nurses' awareness of caring for other patients in similar situations seemed to facilitate the nurses' responses.

In Benner's (1984) study on expert nurses, she found that expert nurses use intuition and are able to anticipate the needs of their patients. Although not all the nurses in this study would meet the criteria for an expert nurse, as defined by Benner, their descriptions of caring in responding to the needs of the patients who identified them demonstrated aspects of the criteria of an expert nurse who uses practical as well as theoretical knowledge. Practical knowledge is developed and extended through the process of reflection and learning from experience. It is interesting to note that one nurse in the present study, who was new to nursing, described asking other nurses with more experience to assist her in providing information to her patient because she felt she didn't have the experience to draw from in telling the patient what usually happens in such situations.

Lemmer (1991) in her descriptions of parents' perceptions of caring following perinatal bereavement described the category 'taking care of' which includes providing expert care. The subcategory of providing expert care reflected parent's expectations that health care providers have to be competent and efficient in meeting physiological and safety needs. Both mothers and fathers perceived the nurses as providing expert nursing care when they were attentive and sensitive to the comfort needs of both the mother and baby. Clayton et al. (1991) from their analysis of the nomination packets of nurses appointed for an Award for Excellence in Oncology Nursing reported the category of professional/ expert knowing. The category is defined as "the knowledge, skills, professional activities, 'ways of knowing and being' that characterize the expert clinician" (p. 158). Both the findings of Lemmer and Clayton et al bear similarities to findings of the present study in regard to the category of responding.

Gaut (1983) in developing a theoretically adequate description of caring, proposes five conditions of caring. These five conditions are awareness, knowledge, intention, means for positive change, and the patient's welfare as being the criterion for judging the action as caring. The ability of the nurse to identify patient's needs involves awareness and various ways of knowing. According to Gaut, "S must have knowledge about X to identify a need for care, and know that certain things could be done to improve the situation" (p. 321). Once the need for care has been identified, the nurse acts in an intentional way to bring about a positive change in the patient. The action is judged solely from the perspective of the recipient of care. Evidence of these conditions is reflected in the caring interactions described by the nurses in the present study.

Doing for Everybody

The nurses in the present study perceived themselves to be caring for these patients the same as they do for all their patients. Kahn and Steeves (1988) in their analysis of nurses' perceptions of caring reported the theme of ideological context. The essence of this theme is that caring is essential to the identity of the nurse. In their study, nurses described caring as part of everything they do. According to Kahn and Steeves, "this theme was termed ideological context because it contains the concepts and the principles that nurses bring with them to encounters with the patients" (p. 206). The findings by Kahn and Steeves are consistent with the findings of the present study.

In Ford's (1990) analysis of nurses' experiences of caring the theme 'beyond the call of duty' emerged. This theme is characterized by intense personal involvement on the part of the nurse. Nurses in the present study described the caring they provided to the patients who identified them as usual or routine caring. The nurses in the present study did not describe intense personal involvement in their relationships with these patients. Some nurses stated that the patient who identified them had not demonstrated any extra need for caring or that their relationship with this patient was relatively short term. Additionally, some nurses in the present study did not recognize that the patient had perceived them as caring. Noddings (1984) contends that for caring to be complete it must be perceived by the recipient of care. The recipient of care is both receptive and responsive to the acts of the one caring. Patients in the present study perceived the nurses as caring, but the nurses did not always necessarily perceive the patient as being receptive and responsive to their caring.

Effects of Caring

Patients Perceptions

There were a few studies reported in the literature which included patients' responses to caring (Miller, Haber, & Byrne, 1992; Paternoster, 1988; Reiman, 1986). Miller, Haber and Byrne reported that nurses perceived that for patients, caring results in increased self-esteem, a sense of trust, and feeling "good, relaxed, comfortable, happy and important" (p. 146). Paternoster reported that patients felt "good, secure, connected, and validated" when they perceived that a nurse cared about them. Reiman related that patients felt "comfortable, relaxed, and secure" as a result of caring interactions with nurses. The findings of these three studies are consistent with the findings reported in the present study. Findings of the present study which are not reported in the literature are that caring interactions help healing. Several nurse theorists (Eriksson, 1992a, 1992b; Parse, 1988; Watson, 1979, 1988) contend that caring affects healing. It is interesting to note that some patients in this study described healing as one of the effects of the caring interactions they experienced.

Nurses Perceptions

Only two studies were found which referred to the effects of caring interactions for nurses (Ford, 1990; Miller, Haber & Byrne, 1992). Ford reported that caring experiences were perceived as being enriching for the nurse but that they also required energy so nurses needed time to recharge between encounters. Miller, Haber & Byrne reported that nurses described caring "as providing them with a 'magical' feeling of deep satisfaction that prompts them to love nursing. If you care, so nurses say, everything else falls right into place; indeed, both nurses and patients feel better" (p. 146). These findings are consistent with those of the present study. However, no studies were found which supported the effect of establishing a closer or more personal relationship with the patient as a response to caring. In the present study, some nurses reported stopping in to see patients even when they were not assigned to care for them. Watson (1988), in her theory of caring, has proposed that caring interactions or caring moments bring the patient and nurse closer together and that those experiences become part of their history which they carry forward to future encounters with the participant and in turn, interactions with others.

Implications and Recommendations

Findings of this study cannot be generalized to the general population for reasons mentioned earlier. However, it is possible to cautiously consider recommendations and implications for nursing practice, education, and research on the basis of these findings and their relevancy to the literature reviewed.

Nursing Practice

The findings of this study point to a number of implications for nursing practice. Both patients and nurses perceived caring to have occurred when the nurse was in tune with the patient's experience and when she responded to the patient's needs. The ability of the nurses to respond to the needs of these patients seemed to be influenced by a number of factors. First, having the opportunity to get to know the patient. In our current healthcare milieu, continuity of care is an often difficult if not impossible goal. However, the benefits of planning staff assignments to best facilitate an ongoing relationship between patient and nurse and continuity of care would seem to outweigh most disadvantages. The nurse's ability to be sensitive and respond to individual patient needs suggests a level of reflection and expertise that must be recognized, developed and nurtured. A number of questions may be raised for administrators and managers in the practice setting: What opportunities exist for nurses to share, reflect and learn from each others' clinical experience? How are novice nurses assisted in the development of practical knowledge in the clinical setting? What value is given to the individual experience of the patient, and how are practitioners sensitized to the experience of the patients for whom they care ?

The nurses in the present study were aware that the patient perceived them as caring when they responded with some overt form of appreciation such as a thank-you. As mentioned previously, several nurses were surprised that the patient had identified them as caring. In nursing it is recognized and accepted that caring does not need to be reciprocated or acknowledged. However, these findings suggest that nurses need to be aware that their caring may be perceived and appreciated although overt acknowledgement has not been expressed. Additionally, that the everyday caring nurses do for each patient is just as important to patients as caring in situations surrounded by more dramatic circumstances. In fact, as so poignantly illustrated by one patient's description of having an intravenous started by two different nurses, routine activities and procedures have the potential to become traumatic when caring is absent. For several patients the little things that the nurse did such as chatting, saying 'hi', being gentle, treating concerns seriously, or asking about them or their family were perceived as caring. These interactions helped the patient to feel like a person, not just a patient. Such moments become significant when they are reflected in the light of a system of health care that often has the potential to depersonalize and dehumanize patients as well as nurses.

In this study, the effects of caring resulted in a profound improvement in affect for patients and a deep sense of satisfaction for nurses. These findings suggest that caring practices need to be supported in practice for two reasons. First, that nurse caring needs to be recognized, valued and promoted in the practice setting because of the potential to increase patient well being. Secondly, that supporting caring practices which provide a rich source of accomplishment for nurses has the potential to increase retention of nurses and decrease burnout.

Nursing Education

The findings of this study may assist in sensitizing nursing students to perceptions of caring from the perspective of patients and nurses in a gynaecological setting and the potential effects of caring for both the patient and the nurse. Additionally, the findings of this study suggest that students may benefit and learn about caring through reflection on their own practice as well as the practice of other nurses. In a more general way, the findings raise several questions for consideration by nurse educators. What opportunities exist for students to be exposed to current theory and research on caring? Can caring be taught or is it mostly an intuitive gift and kind attitude? If being cared for is essential to caring then how are students being cared for by faculty, and who is caring for faculty?

Currently, nurse educators are confronting these and other issues surrounding the development of caring curricula for nursing education (Bevis & Watson, 1989; Leininger & Watson, 1990).

Nursing Research

Several of the findings reported in this study merit additional study. In the literature on caring, there is a lack of reported studies in which the shared meaning of caring (of the one caring and the one cared for) have been reported. Due to the limitations of this study mentioned earlier, additional research is needed to further explore patient-nurse dyads perceptions of shared caring interactions to better understand what is entailed in the giving and receiving of caring. For nurses, it is imperative to understand how intended caring is perceived by the recipient of care. It would be of interest to study patient-nurse dyads in settings other than the one in which the present study was conducted to determine similarities and differences in perceptions of caring interactions. Further study of perceptions of caring according to patient-nurse dyads would expand our understanding of the shared meaning of caring from the perspective of both participants.

Secondly, it would be interesting to learn if nurses' perceptions of caring change with experience. In this study, nurses with the least amount of experience seemed to be primarily focused on emotional aspects of caring, whereas nurses with greater experience seemed to focus on a broader range of activities that constituted caring. Benner (1984) suggests that practical knowledge develops with experience as does sensitivity to the dimensions of nursing care situations.

Another area for further investigation is that of the relationship between caring interactions and the effects of those interactions. In previous studies referred to earlier, participants were generally vague in their ability to describe their responses to caring. In this study, many participants were quite articulate when asked to describe the effects of a particular caring interaction. The link between caring and outcomes of caring might be explored by soliciting patient responses to specific moments or acts of caring.

Additionally, many participants (both patients and nurses) in the present study believed that caring helped healing by improving affect which resulted in earlier discharge or faster recovery. Further research is needed to determine if there is a relationship between caring and healing.

Lastly, exploratory descriptive studies are essential for the development of nursing theory. This study contributes to understanding the nature of caring in the context of nurse-patient dyads. The broad categories of caring identified in this study could be used as building blocks that could lead to the eventual linking and generation of grounded theory.

Summary and Conclusions

The purpose of this study was to gain an understanding of patients' and nurses' perceptions of caring interactions in an acute care setting. An additional purpose was to facilitate a better understanding of the effects of caring interactions for the participants. The research questions which guided this study were: What are the perceptions of both the patient and the nurse of a shared caring interaction? What are the similarities and/or differences in patient and nurse perceptions of a caring interaction? How does the perception of caring affect the patient and the nurse? It is anticipated that the findings posed by these questions may increase nurses' awareness and sensitivity to the role of caring in their nursing practice. Limited research has been reported in which the shared perceptions of a caring interaction have been reported and in that sense this study makes a contribution to the literature on caring.

Eight nurse-patient dyads were interviewed to obtain perceptions of caring interactions. The patients identified the nurses for inclusion in the study. The data, collected through guided interactive interviews, was analyzed by a method of content analysis. Categories of caring interactions from the perspective of patients and nurses were developed. Three major categories of caring were developed from the perspective of patients: Nurses' way, Helping through, and Going beyond. Additionally, three major categories of nurses' caring were developed from the perspective of nurses: Establishing a link, Responding and Doing for everybody. In the present study, patients perceived the Nurse's way to be important to their perceptions of caring, while nurses did not. Nurses, unlike patients, described establishing a link with the patient as crucial to their perception of caring. There were both similarities and differences in patient and nurse perceptions in the patient category of Helping through and the nurse category of Responding. Patients generally perceived nurses in this study to be going beyond in their caring while nurses perceived themselves to be caring in the same way as they do for all patients.

The categories of caring developed during analysis in the present study bear similarities to perceptions of caring reported by other researchers. Most notably, the work of Miller, Haber, & Byrne (1992); Reiman (1986), Swanson-Kauffman (1986, 1988), Swanson (1991). Although the category of going beyond was reported by Ford (1990), the nurses in her study described it differently than patients in the present study. Also, the effects of nurse caring have received limited attention in the reported research, and the subcategory of helps healing has not previously been reported in other studies. The limitations of the study have been presented and implications for nursing practice, education and research have been outlined.

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Appendix A

Information Letter to Patients

Project Title: Caring Interactions: Perceptions of Patients and Nurses

Investigator:	Bernie Pauly BSc.N Graduate Student Faculty of Nursing University of Alberta Office Phone: 492-6676	Advisor: Dr. Darle Forrest Professor Faculty of Nursing University of Alberta Office Phone: 492-5924

Have you experienced caring with a nurse during your hospitalization?

If you can recall that nurse's name, I would like to invite you to be in this study to develop an understanding of caring from the experiences of patients and nurses in hospitals. This research is important in assisting nurses to have a better understanding of what caring means to patients and nurses. People, in this study, would be interviewed twice: once in person and once by telephone after reading a typed copy of the first interview. Each interview will last for about one hour and will be scheduled at a time convenient to you. During the interviews, you will be asked to describe your experiences of caring with nurses.

I am a nurse who has recently returned to university to further my education. This research study is part of the requirement for an advanced degree in nursing. If you are interested in participating in this important study or would like more information, please let the charge nurse know. I will be available to answer any questions that you may have about this study. Thank-you very much for your assistance with this study.

Sincerely,

Bernie Pauly, RN, BSc.N
Graduate Student
Faculty of Nursing

Appendix B

Information Letter to Nurses

Project Title: Caring Interactions: Perceptions of Patients and Nurses

Investigator:	Bernie Pauly BSc.N Graduate Student Faculty of Nursing University of Alberta Office Phone: 492-6676	Advisor: Dr. Darle Forrest Professor Faculty of Nursing University of Alberta Office Phone: 492-5924

What is a caring interaction between a patient and a nurse?
How do these interactions affect patients and nurses?

I am a Master of Nursing student doing a research project aimed at describing perceptions of caring interactions between patients and nurses. This research is important in assisting nurses to have a better understanding of what caring means to patients and nurses. In the study, patients will be asked to identify a nurse with whom they experienced a caring interaction. If you are identified by a patient in this study, you would be asked to be interviewed twice: once in person and once by telephone after reading a typed copy of the first interview. Each interview will last for about one hour and will be scheduled at a time convenient to you and your nursing unit. During the interviews, you would be asked to describe your experiences of caring with patients.

I am a nurse who has recently returned to university to further my education. This research study is part of the requirement for an advanced degree in nursing. If you have any questions about this study, I would be pleased to discuss this project with you further. If you are identified by a particular patient and do not wish to be contacted about this study, please complete the form below and return it to the nurse manager for your unit. Thank-you very much for your assistance with this important study.

Sincerely,

Bernie Pauly, RN, BSc.N
Graduate Student
Faculty of Nursing

If identified by a patient in this study, I do not wish to be contacted.

Name: ______________________________

Unit: ______________________________

Appendix C

Project Title: Caring Interactions: Perceptions of Patients and Nurses

Biographical Data Sheet for Patients

Date: ____________________

Name: ____

Address: ____

____

Age: ________ Occupation: ________________ Sex: __________

Admitting Diagnosis: ____

Date Admitted to Hospital:____________________________________

Number of times hospitalized in past 5 years: __________

Appendix D

Project Title: Caring Interactions: Perceptions of Patients and Nurses

Biographical Information Sheet for Nurses

Date: ______________________

Name: ________________________________

Address: ____________________________________

____

Age: ________________ Nursing Unit: ________

Years of Nursing Experience: ___________________________

Length of Employment on this unit: ___________________

Level of Education: ___________________________________

Past Experience in Nursing: _______________________________

Appendix E

CONSENT FORM
(for patients)

Project Title: Caring Interactions: Perceptions of Patients and Nurses

Investigator:	Bernie Pauly Graduate Student Faculty of Nursing University of Alberta Office Phone: 492-6676	Advisor: Dr. Darle Forrest Professor Faculty of Nursing University of Alberta Office Phone: 492-5924

The purpose of this research project is to increase nurses understanding of the perceptions of patients and nurses of caring interactions during hospitalization. A second purpose is to find out how patients and nurses are affected by these perceptions.

You will be asked to provide the researcher with the name of a nurse who was caring towards you so that she can talk to the nurse about her experiences. If the nurse agrees to be in the study, you will be interviewed at least once in person. The first interview will take place in a private room in the hospital and at a time convenient to you. You will be sent a typed copy of the interview to read and a follow-up telephone interview will be arranged. Interviews will last about one hour. Additional interviews may be arranged if the researcher needs more information about your experiences. All interviews will be tape recorded and then typed word for word so the information that you give the researcher can be reviewed later.

If during this study the researcher becomes a aware of information that may be harmful to yourself or others, the researcher will discuss this with you. Under the law, this information can not be kept confidential. The researcher will inform the appropriate persons and you will be told with whom the researcher spoke.

There will be no harm to you if you participate in this study, nor will you benefit directly from this study. Results from this study may help nurses to understand what patients and nurses believe about caring. This may help to improve the care that nurses give to hospitalized patients.

You do not have to be in this study if you do not wish to be. If you decide to be in the study you may drop out at any time by telling the researcher or the charge nurse. You do not have to answer any questions or discuss any subject in the interview if you do not want to. Taking part in this study or dropping out will not affect your care in the hospital.

Your name will not appear in this study. Only a code number will appear on any forms or question sheets. The tapes of the interviews belong to the researcher, and the researcher will erase your name, and any other identifying material. Written copies of the interview tapes will be made by a typist with the tapes and typed copies identified by a code number, and all names removed to protect the anonymity of the informants. All records will be kept in a locked cabinet. The tapes will be destroyed seven years after the study is completed. The typed interview and notes will remain in a locked file. They may be used for educational and research purposes, if the researcher receives approval from the appropriate ethical review committees.

The tapes will only be shared with Bernie Pauly's research committee from he University of Alberta. The information and findings of this study may be published or presented at conferences but your name or any material that may identify you will not be used.

If you have questions or concerns about this study at any time, you call the researcher, Bernie Pauly.

Consent

I, ________________________________, have read this information and agree to be in the study called "Caring Interactions: Perceptions of Patients and Nurses" I have had a chance to ask whatever questions I have about this study and my part in it. My questions have been answered to my satisfaction. I have been given a copy of this form.

________________________	________________________
Signature of Participant	Date
________________________	________________________
Signature of Researcher	Date

If you wish to receive a summary of the study when it is finished, please complete the next section:

Name: ____

Address: ____

Appendix F

CONSENT FORM
(for nurses)

Project Title: Caring Interactions: Perceptions of Patients and Nurses

Investigator:	Bernie Pauly Graduate Student Faculty of Nursing University of Alberta Office Phone: 492-6676	Advisor: Dr. Darle Forrest Professor Faculty of Nursing University of Alberta Office Phone: 492-5924

The purpose of this research project is to increase nurses understanding of patients and nurses perceptions of caring interactions during hospitalization. A second purpose is to find out how patients and nurses are affected by these perceptions.

Your name was provided to the researcher by a patient. I would like to talk to you about your perceptions of caring in interactions with patients. You will be interviewed at least once in person at a time convenient to you and your nursing unit. You will be sent a typed copy of this interview to read and then a follow-up telephone interview will be conducted. Interviews will last about one hour. Additional interviews may be arranged if the researcher needs more information about your experiences. All interviews will be tape recorded and then typed word for word so the information that you give the researcher can be reviewed later.

There will be no harm to you if you participate in this study, nor will you benefit directly from this study. Results from this study may help nurses to understand what patients and nurses believe about caring. This may help to improve care that nurses give to hospitalized patients.

You do not have to be in this study if you do not wish to be. If you decide to be in the study you may drop out at any time by telling the researcher or the charge nurse. You do not have to answer any questions or discuss any subject in the interview if you do want to. Taking part in this study or dropping out will not affect your employment with the hospital.

Your name will not appear in this study. Only a code number will appear on any forms or question sheets. The tapes of the interviews belong to the researcher, and the researcher will erase your name, and any other identifying material. Written copies of the interview tapes will be made by a typist with the tapes and typed copies identified by a code number, and all names removed to protect the anonymity of the informants. All records will be kept in a locked cabinet. The tapes will be destroyed seven years after the study is completed. The typed interview and notes will be kept in a locked file indefinitely and may be used for education and research purposes providing the researcher receives approval from the appropriate ethical review committees.

The tapes will only be shared with Bernie Pauly's research committee from he University of Alberta. The information and findings of this study may be published or presented at conferences but your name or any material that may identify you will not be used.

If you have questions or concerns about this study at any time, you may call the researcher, Bernie Pauly.

Consent

I, ________________________________, have read this information and agree to be in the study called "Caring Interactions: Perceptions of Patients and Nurses" I have had a chance to ask whatever questions I have about this study and my part in it. My questions have been answered to my satisfaction. I have been given a copy of this form.

________________________	____________________
Signature of Participant	Date
________________________	____________________
Signature of Researcher	Date

If you wish to receive a summary of the study when it is finished, please complete the next section:

Name: ____

Address: ____